

		FOR OHF USE				

LL1

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

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

**I. IDPH Facility ID Number:** 0037077

**Facility Name:** Holly Hill

**Address:** 203 West Lafayette Anna 62906  
 Number City Zip Code

**County:** Union

**Telephone Number:** 618 833-3322 **Fax #** 618 833-4993

**IDPA ID Number:** 371272695001

**Date of Initial License for Current Owners:** 09/07/91

**Type of Ownership:**

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

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

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

**Officer or Administrator of Provider**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Type or Print Name) Richard Stroh

(Title) Asst. Comptroller

**Paid Preparer**

(Signed) \_\_\_\_\_ (Date) \_\_\_\_\_

(Print Name and Title) \_\_\_\_\_

(Firm Name & Address) \_\_\_\_\_

(Telephone) ( ) \_\_\_\_\_ Fax # ( ) \_\_\_\_\_

**MAIL TO: BUREAU OF HEALTH FINANCE**  
**ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES**  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Holly Hill

# 0037077 Report Period Beginning: 1/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 5840

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,705</u>	<u>92</u>		<u>5,797</u>
14	TOTALS	<u>5,705</u>	<u>92</u>		<u>5,797</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.26%

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

43 (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 01/01/91

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

YES  Date 01/01/91 NO

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

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

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

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name &amp; ID Number Holly Hill

# 0037077

Report Period Beginning:

1/1/05

Ending:

12/31/05

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	23,975	1,129	1,346	26,450		26,450		26,450		1
2	Food Purchase		39,210		39,210		39,210		39,210		2
3	Housekeeping	33,453	4,397	989	38,839		38,839	73	38,912		3
4	Laundry		804	120	924		924		924		4
5	Heat and Other Utilities			13,661	13,661		13,661	180	13,841		5
6	Maintenance		2,344	2,942	5,286		5,286	3,752	9,038		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	57,428	47,884	19,058	124,370		124,370	4,005	128,375		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	141,172	2,281	3,670	147,123		147,123	887	148,010		10
10a	Therapy		521	4,838	5,359		5,359		5,359		10a
11	Activities	6,834		235	7,069		7,069		7,069		11
12	Social Services		1,249	2,001	3,250		3,250	(1,111)	2,139		12
13	CNA Training	6,512		2,135	8,647		8,647		8,647		13
14	Program Transportation		2,138	2,162	4,300		4,300	279	4,579		14
15	Other (specify):*			202,649	202,649		202,649	(202,649)			15
16	<b>TOTAL Health Care and Programs</b>	154,518	6,189	221,290	381,997		381,997	(202,594)	179,403		16
	<b>C. General Administration</b>										
17	Administrative	11,964		800	12,764		12,764	4,349	17,113		17
18	Directors Fees							130	130		18
19	Professional Services			24,965	24,965		24,965	(23,759)	1,206		19
20	Dues, Fees, Subscriptions & Promotions			1,885	1,885		1,885	(256)	1,629		20
21	Clerical & General Office Expenses		3,593	4,418	8,011		8,011	7,876	15,887		21
22	Employee Benefits & Payroll Taxes			27,048	27,048		27,048	4,304	31,352		22
23	Inservice Training & Education			103	103		103		103		23
24	Travel and Seminar			289	289		289	5	294		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			1,819	1,819		1,819	157	1,976		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	11,964	3,593	61,327	76,884		76,884	(7,194)	69,690		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	223,910	57,666	301,675	583,251		583,251	(205,783)	377,468		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 Holly Hill

#0037077

Report Period Beginning:

1/1/05

Ending:

12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			12,041	12,041		12,041	14,171	26,212			30
31	Amortization of Pre-Op. & Org.			75	75		75		75			31
32	Interest			8,428	8,428		8,428		8,428			32
33	Real Estate Taxes			6,812	6,812		6,812	126	6,938			33
34	Rent-Facility & Grounds			36,000	36,000		36,000	(35,521)	479			34
35	Rent-Equipment & Vehicles			90	90		90	205	295			35
36	Other (specify):* <b>Bad Debt</b>			1,086	1,086		1,086	(1,086)				36
37	<b>TOTAL Ownership</b>			64,532	64,532		64,532	(22,105)	42,427			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,082	31,082		31,082		31,082			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			31,082	31,082		31,082		31,082			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	223,910	57,666	397,289	678,865		678,865	(227,888)	450,977			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 Holly Hill

# 0037077

Report Period Beginning: 1/1/05

Ending: 12/31/05

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$ (202,649)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(181)	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	13,269	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(200)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,086)	36		24
25	Fund Raising, Advertising and Promotional				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 Pg. 5A	(1,238)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (192,085)		\$	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)	(35,803)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (35,803)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (227,888)		37

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

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

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

OHF USE ONLY					
48		49		50	51
					52

Holly Hill

ID# 0037077

Report Period Beginning: 1/1/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	PAC Dues	\$ (77)	20	1
2	Chamber Membership	(50)	20	2
3	Clothing	(835)	12	3
4	Entertainment	(100)	12	4
5	Donation	(50)	12	5
6	Floral	(126)	12	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	<b>Total</b>	(1,238)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Holly Hill

# 0037077

Report Period Beginning:

1/1/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	73	0	0	0	0	0	0	0	0	0	73	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	180	0	0	0	0	0	0	0	0	0	180	5
6	Maintenance	0	186	3,566	0	0	0	0	0	0	0	0	3,752	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	439	3,566	0	0	0	0	0	0	0	0	4,005	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	887	0	0	0	0	0	0	0	0	887	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	(1,111)	0	0	0	0	0	0	0	0	0	0	(1,111)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	279	0	0	0	0	0	0	0	0	0	279	14
15	Other (specify):*	(202,649)	0	0	0	0	0	0	0	0	0	0	(202,649)	15
16	<b>TOTAL Health Care and Programs</b>	(203,760)	279	887	0	0	0	0	0	0	0	0	(202,594)	16
	<b>C. General Administration</b>													
17	Administrative	0	0	4,349	0	0	0	0	0	0	0	0	4,349	17
18	Directors Fees	0	130	0	0	0	0	0	0	0	0	0	130	18
19	Professional Services	0	241	(24,000)	0	0	0	0	0	0	0	0	(23,759)	19
20	Fees, Subscriptions & Promotions	(327)	71	0	0	0	0	0	0	0	0	0	(256)	20
21	Clerical & General Office Expenses	0	1,233	6,643	0	0	0	0	0	0	0	0	7,876	21
22	Employee Benefits & Payroll Taxes	(181)	4,485	0	0	0	0	0	0	0	0	0	4,304	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5	0	0	0	0	0	0	0	0	0	5	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	157	0	0	0	0	0	0	0	0	0	157	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(508)	6,322	(13,008)	0	0	0	0	0	0	0	0	(7,194)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(204,268)	7,040	(8,555)	0	0	0	0	0	0	0	0	(205,783)	29

STATE OF ILLINOIS

Facility Name & ID Number Holly Hill

# 0037077

Report Period Beginning:

1/1/05

Ending:

Summary B

12/31/05

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	13,269	0	902	0	0	0	0	0	0	0	0	14,171	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	126	0	0	0	0	0	0	0	0	0	126	33
34	Rent-Facility & Grounds	0	479	(36,000)	0	0	0	0	0	0	0	0	(35,521)	34
35	Rent-Equipment & Vehicles	0	0	205	0	0	0	0	0	0	0	0	205	35
36	Other (specify):*	(1,086)	0	0	0	0	0	0	0	0	0	0	(1,086)	36
37	<b>TOTAL Ownership</b>	<b>12,183</b>	<b>605</b>	<b>(34,893)</b>	<b>0</b>	<b>(22,105)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(192,085)</b>	<b>7,645</b>	<b>(43,448)</b>	<b>0</b>	<b>(227,888)</b>	<b>45</b>							

Facility Name & ID Number Holly Hill

# 0037077

Report Period Beginning:

1/1/05

Ending:

12/31/05

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Don J. Pippins	50	Glen Brook	Vienna	kel-Tech Mgmt. Co.	Anna	Mgmt Co.
Christian D. Pippins	50	Liberty house	Marion	JR's Centre, Inc	Anna	Workshop
		Krypton	Metropolis	ILS 1-3	Anna	CILA
		Pilot House	Cairo	ILS 4	Metropolis	CILA
		Lincoln Square	Jonesboro			
		Mulberry Manor	Anna			
		New Way	Anna			

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	3 Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 73	\$ 73 1
2	V	5 Utilities		kel-Tech Management Co.	25.00%	180	180 2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	186	186 3
4	V	14 Transportation		kel-Tech Management Co.	25.00%	279	279 4
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	130	130 5
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	241	241 6
7	V	20 Dues, Fees & Subscriptions		kel-Tech Management Co.	25.00%	71	71 7
8	V	21 Office Expenses		kel-Tech Management Co.	25.00%	1,233	1,233 8
9	V	22 Employee Benefits		kel-Tech Management Co.	25.00%	4,485	4,485 9
10	V	24 Seminar		kel-Tech Management Co.	25.00%	5	5 10
11	V	26 P & C Insurance		kel-Tech Management Co.	25.00%	157	157 11
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	126	126 12
13	V	34 Building Lease		kel-Tech Management Co.	25.00%	479	479 13
14	Total		\$			\$ 7,645	\$ * 7,645 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	Equipment Lease	\$	kel-Tech Management Co.	25.00%	\$ 205	\$ 205	15
16	V	10	Nursing		kel-Tech Management Co.	25.00%	887	887	16
17	V	17	Administration		kel-Tech Management Co.	25.00%	4,349	4,349	17
18	V	21	Clerical		kel-Tech Management Co.	25.00%	6,643	6,643	18
19	V	6	Maintenance		kel-Tech Management Co.	25.00%	3,566	3,566	19
20	V	19	Professional Services	24,000	kel-Tech Management Co.	25.00%		(24,000)	20
21	V	34	Building Lease	36,000	Holly Hill Land Trust			(36,000)	21
22	V	30	Depreciation		kel-Tech Management Co.	25.00%	902	902	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 60,000				\$ 16,552	\$ * (43,448)	39

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

Facility Name & ID Number Holly Hill # 0037077 Report Period Beginning: 1/1/05 Ending: 12/31/05

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Don J. Pippins	ADM/ Owner	Accting/ Mgmt	50.00	89,321	10	25.00	ADM	\$ 11,964	17-1	1
2	Christian D. Pippins	QMRP/ Owner	Prog/ Mgmt	50.00		4	10.00	QMRP	25,964	12-1	2
3	Diana Alley	DON	DON		53,636	4	10.00	DON	11,964	10-1	3
4											4
5											5
6											6
7	kel-Tech Mgmt Co. Allocation:										7
8	Diana Alley							Nursing	887		8
9	Jacob Alley							Maint.	3,566		9
10	James A. Keller							Administration	4,349		10
11											11
12											12
13								TOTAL	\$ 58,694		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 Holly Hill

# 0037077

Report Period Beginning:

1/1/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contributin	360,999	12	\$ 1,100	\$ 24,000	\$ 73	1
2	5	UTILITIES ELECT/GAS	Mgmt Fee Contributin	360,999	12	2,401	24,000	160	2
3	5	UTILITIES WATER-B	Mgmt Fee Contributin	360,999	12	309	24,000	21	3
4	6	GROUNDS MAINT	Mgmt Fee Contributin	360,999	12	416	24,000	28	4
5	6	MAINTENANCE SUPPLIES	Mgmt Fee Contributin	360,999	12	245	24,000	16	5
6	6	MAINTENANCE VEHICLE	Mgmt Fee Contributin	360,999	12	119	24,000	8	6
7	6	PREVENTATIVE MAINT	Mgmt Fee Contributin	360,999	12	99	24,000	7	7
8	6	REPAIRS BLDG	Mgmt Fee Contributin	360,999	12	90	24,000	6	8
9	6	REPAIRS FURN/EQUIP	Mgmt Fee Contributin	360,999	12	1,830	24,000	122	9
10	14	REPAIRS VEHICLES	Mgmt Fee Contributin	360,999	12	246	24,000	16	10
11	14	TRANSPORTATION	Mgmt Fee Contributin	360,999	12	3,953	24,000	263	11
12	18	DIRECTOR'S FEES	Mgmt Fee Contributin	360,999	12	1,950	24,000	130	12
13	19	LEGAL & ACCOUNTING	Mgmt Fee Contributin	360,999	12	3,625	24,000	241	13
14	20	DUES FEES SUBSCRIPTIONS	Mgmt Fee Contributin	360,999	12	1,061	24,000	71	14
15	21	EDUCATIONAL SUPPLIES	Mgmt Fee Contributin	360,999	12	45	24,000	3	15
16	21	BANK CHARGES	Mgmt Fee Contributin	360,999	12	64	24,000	4	16
17	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contributin	360,999	12	243	24,000	16	17
18	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contributin	360,999	12	475	24,000	32	18
19	21	G & A MISC	Mgmt Fee Contributin	360,999	12	484	24,000	32	19
20	21	SUPPLIES STOCK	Mgmt Fee Contributin	360,999	12	793	24,000	53	20
21	21	G & A SUPPLIES	Mgmt Fee Contributin	360,999	12	9,132	24,000	607	21
22	21	POSTAGE	Mgmt Fee Contributin	360,999	12	2,525	24,000	168	22
23	21	SOFTWARE EXPENSE	Mgmt Fee Contributin	360,999	12	825	24,000	55	23
24	21	TELEPHONE	Mgmt Fee Contributin	360,999	12	2,400	24,000	160	24
25	TOTALS					\$ 34,429	\$	\$ 2,292	25

Facility Name & ID Number Holly Hill

# 0037077

Report Period Beginning:

1/1/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	CELL PHONE EXPENSE	Mgmt Fee Contributin	360,999	12	\$ 1,159	\$ 24,000	\$ 77	1	
2	21	UTILITIES-INTERNET	Mgmt Fee Contributin	360,999	12	408	24,000	27	2	
3	22	INS EMP GROUP	Mgmt Fee Contributin	360,999	12	43,812	24,000	2,913	3	
4	22	INSURANCE W/C	Mgmt Fee Contributin	360,999	12	3,770	24,000	251	4	
5	22	PAYROLL TAX EXPENSE	Mgmt Fee Contributin	360,999	12	19,880	24,000	1,322	5	
6	24	ADM. STAFF TRAINING	Mgmt Fee Contributin	360,999	12	79	24,000	5	6	
7	26	INSURANCE BLDG & LIAB	Mgmt Fee Contributin	360,999	12	1,123	24,000	75	7	
8	26	INSURANCE VEHICLES	Mgmt Fee Contributin	360,999	12	1,245	24,000	83	8	
9	33	REAL ESTATE TAXES	Mgmt Fee Contributin	360,999	12	1,893	24,000	126	9	
10	34	LEASE BLDG	Mgmt Fee Contributin	360,999	12	7,200	24,000	479	10	
11	35	LEASE EQUIP	Mgmt Fee Contributin	360,999	12	3,076	24,000	205	11	
12	10	NURSING WAGES	Mgmt Fee Contributin	360,999	12	13,341	13,341	24,000	887	12
13	17	ADMINISTRATION WAGES	Mgmt Fee Contributin	360,999	12	65,419	65,419	24,000	4,349	13
14	21	CELRICAL WAGES	Mgmt Fee Contributin	360,999	12	99,921	99,921	24,000	6,643	14
15	6	MAINTENANCE WAGES	Mgmt Fee Contributin	360,999	12	53,640	53,640	24,000	3,566	15
16	30	DEPRECIATION	Mgmt Fee Contributin	360,999	12	13,569	24,000	902	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 329,536	\$ 232,321	\$ 21,910	25	

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Anna National Bank		X	Remodeling	\$2,400.69	11/5/99	\$ 200,000	\$ 97,029	11/5/09	7.7830	\$ 8,428	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$2,400.69		\$ 200,000	\$ 97,029			\$ 8,428	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 200,000	\$ 97,029			\$ 8,428	15								

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

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

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



**IMPORTANT NOTICE**

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

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

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

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

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

FACILITY NAME Holly Hill COUNTY Union

FACILITY IDPH LICENSE NUMBER 0037077

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE 618 833-5070 FAX #: 618 833-4993

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>14-00-08-178</u>	<u>E. PT Lot 8 W Davies 1st Add</u>	\$ <u>288.00</u>	\$ <u>288.00</u>
2. <u>14-00-08-179</u>	<u>Lot 9 W Davies 1st Add</u>	\$ <u>5,974.00</u>	\$ <u>5,974.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>6,262.00</u>	\$ <u>6,262.00</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? YES X NO

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

**C. Tax Bills**

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

Facility Name & ID Number Holly Hill

# 0037077 Report Period Beginning:

1/1/05 Ending:

12/31/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 3,600 B. General Construction Type: Exterior Wood Frame Wood Number of Stories 2

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

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

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

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

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

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Healthcare</u>	<u>3,600</u>	<u>1991</u>	<u>\$ 16,900</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>3,600</b>		<b>\$ 16,900</b>	<b>3</b>

Facility Name & ID Number Holly Hill

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		2005	1984	\$ 174,600	\$	27.5	\$ 6,085	\$ 6,085	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Driveway Paving		1992	2,500	148	15	125	(23)	2,282	9
10		Carpet		1996	284		7			284	10
11		Improvements		1996	765		7			765	11
12		Leasehold Improvements		1999	196,342	5,034	39	7,854	2,820	30,414	12
13		Heating & Cooling System		1999	2,486	166	15	124	(42)	1,411	13
14		Carpet		1999	13,197	1,178	7	1,320	142	12,607	14
15		Security Alarm		1999	470	42	7	47	5	449	15
16		Improvements		2000	19,670	504	39	787	283	2,878	16
17		Carpet		2000	2,086		7	209	209	2,086	17
18		Fire Alarm		2000	1,933		7	193	193	1,933	18
19		Stair Treads		2002	253	22	7	36	14	197	19
20		Heating & Cooling System		2002	2,239	121	15	149	28	1,154	20
21		Flooring		2004	1,088		7	155	155	1,088	21
22		Drainage System		2005	7,330	61	15	61		61	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

\*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 Holly Hill

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 425,243	\$ 7,276		\$ 17,145	\$ 9,869	\$ 57,609	70

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

Facility Name & ID Number Holly Hill # 0037077 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,355	\$ 119	\$ 193	\$ 74	7	\$ 1,059	71
72	Current Year Purchases	1,432	1,432	251	(1,181)	7	1,432	72
73	Fully Depreciated Assets	25,862		2,142	2,142	7	25,862	73
74								74
75	TOTALS	\$ 28,649	\$ 1,551	\$ 2,586	\$ 1,035		\$ 28,353	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	1984 Van	1984	\$ 13,383	\$	\$	\$	5	\$ 13,383	76
77	Healthcare	2001 Van	2001	27,896	3,214	5,579	2,365	5	26,290	77
78										78
79										79
80	TOTALS			\$ 41,279	\$ 3,214	\$ 5,579	\$ 2,365		\$ 39,673	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)		\$ 512,071	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 12,041	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 25,310	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 13,269	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 125,635	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.

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: Related Party

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 90

Description: Water Cooler

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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)	67	2,140		2,207
4	Clinical Wages (b)	132	4,173		4,305
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	490	1,645		2,135
8	CNA Competency Tests				
9	TOTALS	\$ 689	\$ 7,958	\$	\$ 8,647
10	SUM OF line 9, col. 1 and 2 (e)	\$ 8,647			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>9</b>

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

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

**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 prescripts							9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Exceptional Care Program									12		
13	Other (specify):									13		
14	<b>TOTAL</b>			\$		\$	\$		\$	14		

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

Facility Name & ID Number Holly Hill# 0037077Report Period Beginning: 1/1/05

Ending:

12/31/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 72,436	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	75,540		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)	41,116		8
9	Other(specify): <u>DSP Training Receivable</u>	4,643		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 193,735	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	250,642		15
16	Equipment, at Historical Cost	69,928		16
17	Accumulated Depreciation (book methods)	(125,635)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	292		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 195,227	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 388,962	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 4,742	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	8,708		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,741		31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,450		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 22,641	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	97,029		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 97,029	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 119,670	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 269,292	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 388,962	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>214,121</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>214,121</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>70,171</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(15,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>55,171</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>269,292</b>	<b>24</b> *

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

Facility Name &amp; ID Number Holly Hill

# 0037077

Report Period Beginning: 1/1/05

Ending: 12/31/05

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 531,987	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 531,987	3
<b>B. Ancillary Revenue</b>			
4	Day Care	202,649	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 202,649	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	14,350	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 14,350	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	50	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 50	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 749,036	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	124,370	31
32	Health Care	381,997	32
33	General Administration	76,884	33
<b>B. Capital Expense</b>			
34	Ownership	64,532	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	31,082	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 678,865	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	70,171	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 70,171	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 Holly Hill

# 0037077

Report Period Beginning:

1/1/05

Ending:

12/31/05

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	208	208	\$ 11,964	\$ 57.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	890	890	6,834	7.68	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,162	2,476	23,975	9.68	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,776	3,968	33,453	8.43	18
19	Laundry					19
20	Administrator	520	520	11,964	23.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,037	2,077	25,964	12.50	28
29	Resident Services Coordinator	2,040	2,080	32,340	15.55	29
30	Habilitation Aides (DD Homes)	9,804	10,073	77,416	7.69	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,437	22,292	\$ 223,910 *	\$ 10.04	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	34	\$ 1,346	1-3	35
36	Medical Director	36	3,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	300	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	29	1,770	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	44	2,001	12-3	45
46	Other(specify) <u>Dental Consultant</u>	12	1,200	10-3	46
47	<u>Psychologist/Psychiatrist</u>	38	2,326	10a-3	47
48	<u>Administrative Consultant</u>	11	800	17-3	48
49	TOTAL (lines 35 - 48)	216	\$ 13,343		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 Holly Hill

# 0037077

Report Period Beginning: 1/1/05

Ending: 12/31/05

**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	
Don Pippins	Administrator	50	\$ 11,964	Workers' Compensation Insurance	\$ 4,144	IDPH License Fee	\$	
				Unemployment Compensation Insurance	2,855	Advertising: Employee Recruitment	137	
				FICA Taxes	16,728	Health Care Worker Background Check	212	
				Employee Health Insurance	2,890	(Indicate # of checks performed <u>13</u> )		
				Employee Meals	181			
				Illinois Municipal Retirement Fund (IMRF)*		See Page 24	1,209	
				Employee Physicals	250			
				kel-Tech Alloc.	4,485	kel-Tech Mgmt Allocation	71	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 11,964	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
(List each licensed administrator separately.)				\$ 31,352		\$ 1,629		
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
Connie Dodson			\$ 800				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 800	TOTAL		\$	Seminar Expense	
(Attach a copy of any management service agreement)							ICAN Seminar	289
							kel-Tech Mgmt Alloc	5
C. Professional Services								
Vendor/Payee	Type	Amount						
kel-Tech Management	Mgmt/Accting	\$ 24,000					Entertainment Expense ( )	
FMGR	Legal Services	110					(agree to Sch. V, line 24, col. 8)	
Barnet & Levine	CPA Services	855					TOTAL	
							\$ 294	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 24,965					
(If total legal fees exceed \$2500 attach copy of invoices.)								

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Holly Hill

**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? Yes  
If YES, give association name and amount. IL Healthcare Assoc. \$883
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 263 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. \$ 31,082  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 181 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. Not required of this facility.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

Holly Hill, Inc.  
Analysis of Dues, Fees & Subscriptions  
2005

Resident Bond Fund Renewal	\$ 110.00
Subscriptions	56.00
Corp. Annual Report	130.00
Memberships	30.00
Healthcare Assoc. Dues	883.00
Contributions	200.00
PAC Dues	77.00
Chamber Dues	50.00
Less Non-Allowables:	
Contributions	(200.00)
PAC Dues	(77.00)
Chamber Dues	(50.00)
Total	<u>\$ 1,209.00</u>

Holly Hill, Inc.  
Analysis of Sch. XI, Line 83 to Sch V, Line 30  
2005

Sch V Line 30	\$ 26,212.00
kel-Tech Mgmt. Allocation	<u>(902.00)</u>
Sch XI, Line 83	<u>\$ 25,310.00</u>

Holly Hill, Inc.  
Reconciliation of Book and Tax Income  
Year Ended December 31, 2005

Adjusted book income	\$ 70,171.00
Adjustment for accrual changes from 1/1/05 to 12/31/05	<u>26,059.00</u>
Taxable income per federal income tax return	<u>\$ 96,230.00</u>

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

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