FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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

I. IDPH License ID Number: 0040659

Facility Name: Miller Health Care Center

Address: 1601 Butterfld Trail (Number) Kankakee (City) 60901 (Zip Code)

County: Kankakee

Telephone Number: (815) 936-6500 **Fax #** (815) 936-6502

HFS ID Number:

Date of Initial License for Current Owners: 02/13/1995

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2014 to 12/31/2014 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	50	Intermediate/DD	50	18,250	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		8,284	20,229	28,513	8
9	SNF/PED					9
10	ICF	2,404	12,715		15,119	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,404	20,999	20,229	43,632	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.71%

D. How many bed-hold days during this year were paid by the Department?
20 (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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/13/1995

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/13/1995 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 110 and days of care provided 20,229

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Miller Health Care Center # 0040659 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	472,010	57,467	35,270	564,747		564,747		564,747			1
2	Food Purchase		371,440		371,440		371,440	(37,372)	334,068			2
3	Housekeeping	202,823	57,594	93,806	354,223		354,223	(16,538)	337,685			3
4	Laundry											4
5	Heat and Other Utilities			235,733	235,733		235,733		235,733			5
6	Maintenance	75,961	8,155	154,839	238,955		238,955	5,350	244,305			6
7	Other (specify):*											7
8	**TOTAL General Services**	750,794	494,656	519,648	1,765,098		1,765,098	(48,560)	1,716,538			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,436,614	915,215	137,017	5,488,846		5,488,846		5,488,846			10
10a	Therapy											10a
11	Activities	225,236	5,225	12,570	243,031		243,031		243,031			11
12	Social Services	99,461			99,461		99,461		99,461			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,761,311	920,440	149,587	5,831,338		5,831,338		5,831,338			16
	C. General Administration											
17	Administrative	120,387			120,387		120,387		120,387			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			9,840	9,840		9,840	7,200	17,040			20
21	Clerical & General Office Expenses	512,239	28,604	136,532	677,375		677,375	2,303,791	2,981,166			21
22	Employee Benefits & Payroll Taxes			1,697,139	1,697,139		1,697,139	(92,717)	1,604,422			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,929	1,929		1,929		1,929			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			81,739	81,739		81,739		81,739			26
27	Other (specify):* **Mgmt. Co Benefits**							82,378	82,378			27
28	**TOTAL General Administration**	632,626	28,604	1,927,179	2,588,409		2,588,409	2,300,652	4,889,061			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,144,731	1,443,700	2,596,414	10,184,845		10,184,845	2,252,092	12,436,937			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 Miller Health Care Center #0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			646,744	646,744		646,744	(12,102)	634,642			30
31	Amortization of Pre-Op. & Org.			9,728	9,728		9,728		9,728			31
32	Interest			614,548	614,548		614,548	(13,205)	601,343			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **Bond Costs**			6,800	6,800		6,800		6,800			36
37	**TOTAL Ownership**			1,277,820	1,277,820		1,277,820	(25,307)	1,252,513			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		106,200	2,342,726	2,448,926		2,448,926		2,448,926			39
40	Barber and Beauty Shops			20	20		20		20			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			242,087	242,087		242,087		242,087			42
43	Other (specify):* **Non-Allowable Cos**	262,143		12,805	274,948		274,948	(274,948)				43
44	**TOTAL Special Cost Centers**	262,143	106,200	2,597,638	2,965,981		2,965,981	(274,948)	2,691,033			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,406,874	1,549,900	6,471,872	14,428,646		14,428,646	1,951,837	16,380,483			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 Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(37,372)	2		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	(16,538)	4		8
9	Non-Straightline Depreciation	(12,102)	30		9
10	Interest and Other Investment Income	(13,205)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,105)	43		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 Page 5A	(264,493)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (348,815)		$	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 Amount	2 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)	2,300,652		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,300,652		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,951,837		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Miller Health Care Center

ID# 0040659

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Cable	$ (7,039)	43	1
2	Admitting Professional	(262,143)	43	2
3	Admitting Expense	(661)	43	3
4	To expense building improvements under $2500	5,350	6	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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25				25
26				26
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30				30
31				31
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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**	(264,493)		49

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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
Riverside Health System	100			Riverside Medical Cen	Kankakee	Hospital
				Riverside Senior Livin	Kankakee	Senior Living
				Oakside Corporation	Kankakee	DME/Retail Rx

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	4	Linen	$ 40,619	Riverside Medical Center		$ 40,619	$	1
2	V	10	DON salary	107,227	Riverside Medical Center		107,227		2
3	V	10	Med Supplies and Medication	20,011	Oakside Corporation		20,011		3
4	V	10	Purchased Services	167,497	Riverside Medical Center		167,497		4
5	V	17	Administrator salary	112,362	Riverside Medical Center		112,362		5
6	V	21	Administrative services	12,000	Riverside Medical Center		2,322,991	2,310,991	6
7	V	21	Employee drug testing	4,800	Riverside Medical Center		4,800		7
8	V	22	Benefits	92,717	Riverside Medical Center			(92,717)	8
9	V	27	Benefits		Riverside Medical Center		82,378	82,378	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 557,233			$ 2,857,885	$ * 2,300,652	14

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Please see attached listing of board of directors.			0.00	None	<1	<1%		$ None		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		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 Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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 [X]

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

Name of Related Organization: Riverside Medical Center
Street Address: 350 N. Wall Street
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815) 933-1671
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	Linen	Cost	1		$ 40,619	$	1	$ 40,619	1
2	10	DON salary	Cost	1		107,227		1	107,227	2
3	10	Med Supplies and Medication	Cost	1		20,011		1	20,011	3
4	10	Purchased Services	Cost	1		167,497		1	167,497	4
5	17	Administrator salary	Cost	1		112,362		1	112,362	5
6	21	Administrative services	Cost	213,071,345		34,304,171	101,458,936	14,428,649	2,322,991	6
7	21	Employee drug testing	Cost	1		4,800		1	4,800	7
8	27	Benefits	Cost	1		82,378		1	82,378	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	TOTALS					$ 34,839,065	$ 101,458,936		$ 2,857,885	25

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bond-1994	X		Building Construction		1994	$ 5,152,000	$ 1,521,633	2019	Var	$ 2,854	1
2	Bond-2004	X		Partial Refinancing of 2000 bonds		2004	757,371	411,214	2029	Var	15,453	2
3	Bond-2009	X		Partial Refinancing of 2004 bonds		2009	9,594,258	7,187,476	2035	6.0000	596,241	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 15,503,629	$ 9,120,323			$ 614,548	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(13,205)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (13,205)	14
15	TOTALS (line 9+line14)						$ 15,503,629	$ 9,120,323			$ 601,343	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #** N/A

*** 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.)**

Facility Name & ID Number Miller Health Care Center # 0040659 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	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.)	**2013**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$	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.)**	**Allocated from Managment Co.**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009		**8**
	2010		**9**
	2011		**10**
	2012		**11**
	2013		**12**

Not-for- profit organization no real estate taxes are paid.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Miller Health Care Center COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0040659

CONTACT PERSON REGARDING THIS REPORT NA

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Not-for- profit organization no real estate taxes are paid.		$ NA	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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? NA 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 81,649 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Skilled Nursing Facility		1991	$ 886,000	1
2					2
3	TOTALS			$ 886,000	3

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1995	1995	$ 3,539,943	$ 65,018	35.37881	$ 65,018	$	$ 2,446,227	4
5	10		1999	1999	656,641	22,282	17.56418	22,282		574,197	5
6	10		2001	2001	147,085	62	21.31046	62		146,991	6
7	40		2009	2009	7,937,516	187,188	3.65101	187,188		1,052,541	7
8											8
	Improvement Type**										
9	Land Improvements			1995	63,411					63,411	9
10	Building Service Equipment			1995	1,295,587	43,385	24.92142	43,385		1,167,960	10
11	Land Improvements-Landscaping			1997	4,688					4,688	11
12	Land Improvements-Walkways			1998	15,388		14.5122			15,388	12
13	Building-Carpeting			1998	2,370					2,370	13
14	Land Improvements-Landscaping and pond dec			1999	25,379					25,379	14
15	Building-Carpeting			2000	3,125					3,125	15
16	Building Service Equipment-Exterior Lighting			2000	1,100	61	12.5082	61		885	16
17	Land Improvements-Landscaping			2001	16,069	418		418		15,443	17
18	Building Service Equipment-HVAC			2001	2,551	127		127		1,722	18
19	Land Improvements-Courtyard Concrete			2002	640	32		32		400	19
20	Building Service Equipment-HVAC/Water Heater			2002	9,547	145		145		9,183	20
21	Building Service Equipment-HVAC/Water Heater			2003	5,003	124		124		4,571	21
22	Land Improvements-Gazebo			2004	510	26		26		268	22
23	Building Service Equip-waterline/sprinkler system revision			2004	8,208	386		386		5,265	23
24	Building-Carpeting/wallcoverings/lighting			2004	94,121	1,364		1,364		94,121	24
25	Building-Carpeting/wallcoverings/painting/ceiling tile			2005	205,826	1,640		1,640		205,007	25
26	Land Improvements-Asphalt walkway			2005	7,574					7,574	26
27	Building Service Equip-water heater/generator/doors/compressor/HVAC			2005	8,142	647		647		6,151	27
28	Building-cabinets/doors/wall coverings			2006	131,916	2,294		2,294		120,151	28
29	Building Service Equipment-HVAC/electrical/plumbing			2006	22,864	1,488		1,488		12,650	29
30	Building-Physical Therapy renovation			2007	21,417	1,664		1,664		12,485	30
31	Building Service Equipment-Fire Alarm Upgrade			2007	6,448	562		562		4,217	31
32	Land Improvements-Pergola and landscaping			2008	15,903	1,517		1,517		9,861	32
33	Building-Carpeting/wallcoverings/lighting			2008	56,241	3,046		3,046		45,177	33
34	Building Service Equip-Sprinkler/electrical/HVAC/plumbing			2008	28,343	1,387		1,387		10,002	34
35	Building Service Equip-Lighting Fixtures			2009	3,718	372		372		2,046	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 Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Service Equip-Fire Suppression System	2009	$ 2,021	$ 81	3.5	$ 81	$	$ 445	37
38	Building Service Equip-Back-up Generator	2009	980	55	3.5	55		299	38
39	Building Service Equip-Hood Exhaust System	2009	2,011	134	3.5	134		737	39
40	Building Service Equip-HVAC Unit	2009	2,758	276	3.5	276		2,758	40
41	Building Service Equip-Electric Auto Doors	2009	8,873	887	3.5	887		4,879	41
42	Building Service Equip-Emergency Generator	2010	4,218	211	3.5	211		949	42
43	Building Service Equip-HVAC Units	2010	5,651	377	2.5	377		1,696	43
44	Building Service Equip-Waterheaters	2010	16,644	1,664	2.5	1,664		7,489	44
45	Land Improvements-Enclosure Gates	2010	2,551	425	2.5	425		2,551	45
46	Building Student Room Wallcovering, Flooring, Lighting	2011	2,881	170	1.5	170		593	46
47	Building Copier Power Supply	2011	1,004	56	1.5	56		196	47
48	Building-Dinning Room Flooring	2011	1,540	154	1.5	154		539	48
49	Building-Exit Lights	2011	1,155	77	1.5	77		270	49
50	Building-Wallcovering, Flooring, Lighting in Corridors	2011	77,025	4,531	1.5	4,531		15,858	50
51	Building-Day Room Flooring	2011	5,993	599	1.5	599		2,097	51
52	Building-Media Room Replacement Doors	2011	1,947	130	1.5	130		455	52
53	Building Service Equip-HVAC Replacement	2011	2,921	195	1.5	195		682	53
54	Building Service Equip-Kitchen Drain Line Replacement	2011	969	49	1.5	49		169	54
55	Building Service Equip-Emergency Generator Rebuild	2011	2,764	138	1.5	138		483	55
56	Building Service Equip-Partial Roof Replacement	2011	1,019	102	1.5	102		357	56
57	Building Service Equip-HVAC Replacement	2011	2,350	157	1.5	157		549	57
58	Building-Electrical Outlets	2011	2,688	149	1.5	149		373	58
59	Building-Sprinkler Heads	2012	8,360	334	1	334		835	59
60	Building-Electronic Door Closers	2012	1,275	85	1	85		213	60
61	Building-Smoke Detectors	2012	1,412	141	1	141		353	61
62	Building Service Equip-Generator Emergency Stops	2012	6,905	575	1	575		1,438	62
63	Building Service Equip-Generator Emergency Stops	2012	2,074	173	1	173		432	63
64	Building Service Equip-Dishwasher Electrical	2012	4,987	277	1	277		693	64
65	Building Service Equip-Pole Lighting	2012	3,003	200	1	200		500	65
66	Building Service Equip-Water Valves	2012	3,642	182	1	182		455	66
67									67
68	Land Improvements - Asphalt work, sealing, stripping and crack fi	2013	16,575	8,053	6	8,053		12,080	68
69	Building Service Equip - Carpet replacement in common area and	2013	12,886	2,259	11	2,259		3,389	69
70	TOTAL (lines 4 thru 69)		$ 14,548,356	$ 358,131		$ 358,131	$	$ 6,134,268	70

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 14,548,356	$ 358,131		$ 358,131	$	$ 6,134,268	1
2	Building Service Equip - Suites kitchen ceiling tile replacement	2013	5,239	524	10	524		786	2
3	Building Service Equip - duct insulation in suites J, K halls and kit	2013	18,390	919	20	919		1,379	3
4	Building Service Equip - Replacement of courtyard doors and new	2013	3,766	286	15	286		429	4
5	Building Service Equip - Installation of Conduit to patient room ar	2013	4,245	226	20	226		339	5
6	Building Service Equip - Replace side roof HVAC Unit	2013	14,492	1,449	10	1,449		2,174	6
7	Building Service Equip - Replace power supply and celing fans in c	2013	2,299	151	18	151		226	7
8	Building Service Equip - Replace water heaters and repaired water	2013	20,271	1,893	25	1,893		2,840	8
9	Building Service Equip - TV's for skilled and intermediate commor	2013	6,185	1,237	5	1,237		1,856	9
10									10
11	Building Service Equip - Remodel of bathroom in F101 Frozen pip	2014	11,369	334	17	334		334	11
12	Plumbing and general construction. Break a hole in the ceiling,								12
13	replace the pipe to fix the leak, patch back up, repair and paint								13
14	from the water damage.								14
15	Building Service Equip - circuit board replacement for emergency	2014	9,641	402	12	402		402	15
16	Building Service Equip - Replacement controls and upgrade board	2014	5,602	225	15	225		225	16
17	Building Service Equip - Smoke detection & annunciator fire alarn	2014	85,705	4,285	10	4,285		4,285	17
18	Building Service Equip - Update 5 bathrooms and storage area 1/2	2014	30,000	882	17	882		882	18
19	Install Drywall, Painting and Electrical for Women's Bathroom								19
20	Hall A and Men's Bathroom Hall B								20
21	Building Service Equip - Electrical express locks of suites main ent	2014	6,160	308	10	308		308	21
22	Building Service Equip - Replacement of electronics for suites nurs	2014	4,704	235	10	235		235	22
23									23
24									24
25	To Reconcile to book depreciation			12,102			(12,102)		25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,776,424	$ 383,589		$ 371,487	$ (12,102)	$ 6,150,968	34

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	$ 3,697,232	$ 256,841	$ 256,841	$	3-20	$ 2,287,564	71
72	Current Year Purchases	80,449	6,314	6,314		5-20	6,314	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 3,777,681	$ 263,155	$ 263,155	$		$ 2,293,878	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	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 19,440,105	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 646,744	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 634,642	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (12,102)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,444,846	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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 Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 0 Description: N/A
    (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	N/A		$	$	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 Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39 C3	hrs	$	13,042	$ 747,596	$	13,042	$ 747,596	1
2	Licensed Speech and Language Development Therapist	L39 C3	hrs		7,390	380,840		7,390	380,840	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39 C3	hrs		22,817	1,214,290		22,817	1,214,290	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): Therapy Equipment	L39 C2					106,200		106,200	12
13	Other (specify):									13
14	TOTAL			$	43,249	$ 2,342,726	$ 106,200	43,249	$ 2,448,926	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.

STATE OF ILLINOIS

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ 1,527,994	$ 1,527,994	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 388,915)	2,170,503	2,170,503	3
4	Supply Inventory (priced at)	8,252	8,252	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	25,275	25,275	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,732,024	$ 3,732,024	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		886,000	13
14	Buildings, at Historical Cost	13,095,002	12,281,185	14
15	Leasehold Improvements, at Historical Cost	1,686,772	2,495,239	15
16	Equipment, at Historical Cost	3,777,681	3,777,681	16
17	Accumulated Depreciation (book methods)	(8,445,141)	(8,444,846)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	126,550	126,550	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(126,550)	(126,550)	20
21	Restricted Funds			21
22	Other Long-Term Assets (sp See SCH 17A	13,112,574	13,112,574	22
23	Other(specify): Trustee held assets	1,010,518	1,010,518	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 24,237,406	$ 25,118,351	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 27,969,430	$ 28,850,375	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 403,089	$ 403,089	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	306,113	306,113	29
30	Accrued Salaries Payable	787,056	787,056	30
31	Accrued Taxes Payable (excluding real estate taxes)	147,427	147,427	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	72,764	72,764	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See SCH 17A	21,601	21,601	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,738,050	$ 1,738,050	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	8,814,210	8,814,210	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Third Party	5,053,312	5,053,312	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 13,867,522	$ 13,867,522	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,605,572	$ 15,605,572	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 12,363,858	$ 13,244,803	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 27,969,430	$ 28,850,375	48

*(See instructions.)

Facility Name: **Miller Health Care Center**
IDPH License ID Number: **0040659**
Fiscal Year End: **12/31/2014**

Schedule 17A

XV. Balance Sheet
Line 22 Other Long-Term Assets (specify):

Description	Operating	After Consolidation
Bond Issue Costs, 1994 Bond Issue Costs	3,337	3,337
Bond Issue Costs, 2004 Bond Issue Costs	948	948
Bond Issue Costs, 2009 Bond Issue Costs	124,743	124,743
Due From Third Party, Due From SLC	12,883,546	12,883,546
Due From Third Party, Due From Medicare	100,000	100,000
Total - Line 23	**13,112,574**	**13,112,574**
		-

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Salary & Deductions,Pension Pay - GW	73,955	73,955
Salary & Deductions,Life Dep Disab	63,005	63,005
Salary & Deductions,General Wellness	(94)	(94)
Salary & Deductions,Trust Mark	447	447
Salary & Deductions,Occidental Life	(18,367)	(18,367)
Salary & Deductions,United Way Pay	66	66
Salary & Deductions,Hlth & Fitness	-	-
Salary & Deductions,Samaritan	(1,469)	(1,469)
Salary & Deductions,Lead With Your Heart	360	360
Salary & Deductions,Hosp Bill	6,170	6,170
Salary & Deductions,Day Care Pay	(200)	(200)
Salary & Deductions,Garn	26,151	26,151

Salary & Deductions,Gift Shop Pay	3,281	3,281
Salary & Deductions,Personal Deduct	268	268
Salary & Deductions,Nursing Excellence	(23)	(23)
Salary & Deductions,RN License Renewal	840	840
Salary & Deductions,Family Pharmacy	1,452	1,452
Salary & Deductions,RHE Uniform Ded	(5,154)	(5,154)
Salary & Deductions,Vendor Fair	(268)	(268)
Salary & Deductions,Noncash Cr Acct	(3,682)	(3,682)
Accrued Expenses,Public Aid Tax	(124,787)	(124,787)
Accrued Expenses,Other	(350)	(350)
	21,601	**21,601**
		-

Facility Name & ID Number Miller Health Care Center **#** 0040659 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,470,032	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment**	2,502	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,472,534	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	891,324	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)**	$ 891,324	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)**	$ 12,363,858	24	*

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,963,391	1
2	Discounts and Allowances for all Levels	(5,183,840)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,779,551	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,360,723	6
7	Oxygen	730	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,361,453	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	26,697	13
14	Non-Patient Meals	37,372	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	725,508	17
18	Sale of Supplies to Non-Patients	538,817	18
19	Laboratory	586,759	19
20	Radiology and X-Ray	168,232	20
21	Other Medical Services	2,370	21
22	Laundry	16,538	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,102,293	23
	D. Non-Operating Revenue		
24	Contributions	1,921	24
25	Interest and Other Investment Income***	13,205	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,126	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See SCH 19A	61,547	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 61,547	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,319,970	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,765,098	31
32	Health Care	5,831,338	32
33	General Administration	2,588,409	33
	B. Capital Expense		
34	Ownership	1,277,820	34
	C. Ancillary Expense		
35	Special Cost Centers	2,723,894	35
36	Provider Participation Fee	242,087	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,428,646	40
41	**Income before Income Taxes (line 30 minus line 40)****	891,324	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 891,324	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 302,788	44
45	Private Pay - Net Inpatient Revenue	3,990,810	45
46	Medicare - Net Inpatient Revenue	(514,047)	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,779,551	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.**

^ - this entity is a cash basis taxpayer

Facility Name: **Miller Health Care Center**
IDPH License ID Number: **0040659**
Fiscal Year End: **12/31/2014**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
Derivative Valuation	18,358
Grant Revenue	(11,538)
Trustee Restr	21,691
Sr. Advantage, Grant Offset	(1,194)
Admin, Trustee Realized G/L	(8,718)
Admin, Trustee Unrealized G/L	42,948
Total - Line 28	**61,547**

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,123	1,948	$ 112,477	$ 57.74	1
2	Assistant Director of Nursing	2,446	2,252	108,202	48.05	2
3	Registered Nurses	64,648	59,491	2,010,944	33.80	3
4	Licensed Practical Nurses	39,264	35,794	878,664	24.55	4
5	CNAs & Orderlies	112,438	102,145	1,326,327	12.98	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	13,631	12,432	225,236	18.12	10
11	Social Service Workers	4,829	4,209	99,461	23.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	43,526	40,409	472,010	11.68	15
16	Dishwashers					16
17	Maintenance Workers	2,208	1,967	75,961	38.62	17
18	Housekeepers	17,488	16,099	202,823	12.60	18
19	Laundry					19
20	Administrator	2,406	1,748	120,387	68.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	29,741	27,353	512,239	18.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca					32
33	Other(specify) Admissions Co-ord	13,453	12,045	262,143	21.76	33
34	TOTAL (lines 1 - 33)	348,201	317,892	$ 6,406,874 *	$ 20.15	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	846	$ 29,610	1(3)	35
36	Medical Director	Monthly	12,000	10(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,020	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	846	$ 51,630		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ N/A		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nora O'gorman	Administrator	0	$ 120,387
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 120,387

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
N/A		$
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,668
Unemployment Compensation Insurance	
FICA Taxes	472,999
Employee Health Insurance	946,878
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	150,708
Dental Insurance	19,763
Disability Ins	16,762
Gainshare/Incentive	(642)
Employee Life Insurance	25,003
Reclassed to Sch V Ln 27	(92,717)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,604,422

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	0
Health Care Worker Background Check	
(Indicate # of checks performed 720)	
Patient Background Checks	7,200
Miscellaneous Dues	1,358
Healthmedx	292
Care 2 Learn	5,040
Realias Learning, LLC	3,150
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,040

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,929
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,929

**See instructions.

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3												N/A	
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. **N/A**

(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? **N/A**

(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? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,518** 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. **N/A**

(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. $ **242,087**
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? **Yes**

(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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **37,372**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **No**
Attach invoices and a summary of services for all architect and appraisal fees.