FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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 Butterfield Tr (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 01/01/2015 to 12/31/2015 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) RSM US 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: 01/01/2015 Ending: 12/31/2015

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			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		8,765	19,541	28,306	8
9	SNF/PED					9
10	ICF	1,727	13,854		15,581	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,727	22,619	19,541	43,887	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.15%

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 19,541

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Miller Health Care Center # 0040659 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	513,378	390,380	43,356	947,114		947,114	(52,907)	894,207			1
2	Food Purchase		49,457		49,457		49,457		49,457			2
3	Housekeeping	239,509	63,789	81,242	384,540		384,540	(12,928)	371,612			3
4	Laundry											4
5	Heat and Other Utilities			277,220	277,220		277,220		277,220			5
6	Maintenance	6,346	1,113	152,000	159,459		159,459	6,122	165,581			6
7	Other (specify):*											7
8	**TOTAL General Services**	759,233	504,739	553,818	1,817,790		1,817,790	(59,713)	1,758,077			8
	B. Health Care and Programs											
9	Medical Director							9,000	9,000			9
10	Nursing and Medical Records	4,549,612	1,049,015	297,198	5,895,825		5,895,825	(20,507)	5,875,318			10
10a	Therapy											10a
11	Activities	240,318	5,542	4,712	250,572		250,572		250,572			11
12	Social Services	79,459			79,459		79,459		79,459			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,869,389	1,054,557	301,910	6,225,856		6,225,856	(11,507)	6,214,349			16
	C. General Administration											
17	Administrative	175,298			175,298		175,298		175,298			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			15,732	15,732		15,732	4,013	19,745			20
21	Clerical & General Office Expenses	444,489	20,746	95,202	560,437		560,437	2,425,000	2,985,437			21
22	Employee Benefits & Payroll Taxes			1,570,823	1,570,823		1,570,823	(90,564)	1,480,259			22
23	Inservice Training & Education							3,027	3,027			23
24	Travel and Seminar			3,109	3,109		3,109		3,109			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,036	74,036		74,036		74,036			26
27	Other (specify):* **Mgmt. Co Benefits**							39,337	39,337			27
28	**TOTAL General Administration**	619,787	20,746	1,758,902	2,399,435		2,399,435	2,380,813	4,780,248			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,248,409	1,580,042	2,614,630	10,443,081		10,443,081	2,309,593	12,752,674			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: 01/01/2015 Ending: 12/31/2015

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			629,452	629,452		629,452	(45,849)	583,603			30
31	Amortization of Pre-Op. & Org.			9,072	9,072		9,072		9,072			31
32	Interest			470,725	470,725		470,725	(5,551)	465,174			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							40,883	40,883			35
36	Other (specify):* **Bond Costs**			4,174	4,174		4,174		4,174			36
37	**TOTAL Ownership**			1,113,423	1,113,423		1,113,423	(10,517)	1,102,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,911	2,464,994	2,548,905		2,548,905	(29,376)	2,519,529			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			226,152	226,152		226,152		226,152			42
43	Other (specify):* **Non-Allowable Cos**	312,767		21,119	333,886		333,886	(333,886)				43
44	**TOTAL Special Cost Centers**	312,767	83,911	2,712,265	3,108,943		3,108,943	(363,262)	2,745,681			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,561,176	1,663,953	6,440,318	14,665,447		14,665,447	1,935,814	16,601,261			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: 01/01/2015 Ending: 12/31/2015

VI. ADJUSTMENT DETAIL

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

	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	(52,907)	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	(12,928)	4		8
9	Non-Straightline Depreciation	(45,849)	30		9
10	Interest and Other Investment Income	(5,551)	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	(13,511)	43		24
25	Fund Raising, Advertising and Promotional	(584)	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	(315,449)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (446,779)		$	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)	2,382,593		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,382,593		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,935,814		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: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Cable	$ (7,024)	43	1
2	Admitting Professional	(312,767)	43	2
3	To expense building improvements under $2500	6,122	6	3
4	Reconcile Dues & Subs to support	2,540	20	4
5	Non-Allowable Lobbying Fee	(4,320)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
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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**	(315,449)		49

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. [X] 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	$ 63,441	Riverside Medical Center		$ 63,441	$	1
2	V	10	DON salary	110,969	Riverside Medical Center		110,969		2
3	V	10	Med Supplies and Medication	85,730	Oakside Corporation		85,730		3
4	V	10	Purchased Services	259,869	Riverside Medical Center		259,869		4
5	V	17	Administrator salary	83,284	Riverside Medical Center		83,284		5
6	V	21	Administrative services	12,000	Riverside Medical Center		2,445,820	2,433,820	6
7	V	21	Employee drug testing	4,800	Riverside Medical Center		4,800		7
8	V	22	Benefits	90,564	Riverside Medical Center			(90,564)	8
9	V	27	Benefits		Riverside Medical Center		39,337	39,337	9
10	V	39	Therapy Services	19,572	Riverside Medical Center		19,572		10
11	V								11
12	V								12
13	V								13
14	Total			$ 730,229			$ 3,112,822	$ * 2,382,593	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: 01/01/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

	1	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					$		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: 01/01/2015 Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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		$ 63,441	$	1	$ 63,441	1
2	10	DON salary	Cost	1		110,969		1	110,969	2
3	10	Med Supplies and Medication	Cost	1		85,730		1	85,730	3
4	10	Purchased Services	Cost	1		259,869		1	259,869	4
5	17	Administrator salary	Cost	1		83,284		1	83,284	5
6	21	Administrative services	Cost	218,513,307		36,442,399	100,743,906	14,665,449	2,445,820	6
7	21	Employee drug testing	Cost	1		4,800		1	4,800	7
8	27	Benefits	Cost	1		39,337		1	39,337	8
9	39	Therapy Services	Cost	1		19,572		1	19,572	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					$ 37,109,401	$ 100,743,906		$ 3,112,822	25

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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	$ 1,237,939	2019	Var	$ 2,276	1
2	Bond-2004	X		Partial Refinancing of 2000 bon		2004	757,371		2029	Var	10,991	2
3	Bond-2009	X		Partial Refinancing of 2004 bon		2009	9,594,258	7,191,404	2035	6.00	452,795	3
4	Bond-2015	X		Direct Replacement		2015	388,674	388,674	2029	Var	4,663	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 15,892,303	$ 8,818,017			$ 470,725	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(5,551)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,551)	14
15	TOTALS (line 9+line14)						$ 15,892,303	$ 8,818,017			$ 465,174	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:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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.)	**2014**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2015 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:			
	2010		**8**
	2011		**9**
	2012		**10**
	2013		**11**
	2014		**12**

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Miller Healthcare 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 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A) 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.		$	$
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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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. [X] (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: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 57,999	44	$ 57,999	$	$ 2,504,226	4
5	10		1999	1999	656,641	14,828	30	14,828		589,025	5
6	10		2001	2001	147,085	63	15	63		147,054	6
7	40		2009	2009	7,937,516	186,406	44	186,406		1,238,947	7
8											8
	Improvement Type**										
9	Land Improvements			1995	63,411					63,411	9
10	Building Service Equipment			1995	1,295,587	26,226	25	26,226		1,194,186	10
11	Land Improvements-Landscaping			1997	4,688					4,688	11
12	Land Improvements-Walkways			1998	15,388		15			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	18	61		946	16
17	Land Improvements-Landscaping			2001	16,069	417		417		15,860	17
18	Building Service Equipment-HVAC			2001	2,551	128		128		1,850	18
19	Land Improvements-Courtyard Concrete			2002	640	32		32		432	19
20	Building Service Equipment-HVAC/Water Heater			2002	9,547	146		146		9,329	20
21	Building Service Equipment-HVAC/Water Heater			2003	5,003	123		123		4,694	21
22	Land Improvements-Gazebo			2004	510	25		25		293	22
23	Building Service Equip-waterline/sprinkler system revision			2004	8,208	259		259		5,524	23
24	Building-Carpeting/wallcoverings/lighting			2004	94,121					94,121	24
25	Building-Carpeting/wallcoverings/painting/ceiling tile			2005	205,826	819		819		205,826	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	491		491		6,642	27
28	Building-cabinets/doors/wall coverings			2006	131,916	2,294		2,294		122,445	28
29	Building Service Equipment-HVAC/electrical/plumbing			2006	22,864	1,488		1,488		14,138	29
30	Building-Physical Therapy renovation			2007	21,417	1,665		1,665		14,150	30
31	Building Service Equipment-Fire Alarm Upgrade			2007	6,448	563		563		4,780	31
32	Land Improvements-Pergola and landscaping			2008	15,903	1,517		1,517		11,378	32
33	Building-Carpeting/wallcoverings/lighting			2008	56,241	3,048		3,048		48,225	33
34	Building Service Equip-Sprinkler/electrical/HVAC/plumbing			2008	28,343	1,389		1,389		11,391	34
35	Building Service Equip-Lighting Fixtures			2009	3,718	372		372		2,418	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: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 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	25	$ 81	$	$ 526	37
38	Building Service Equip-Back-up Generator	2009	980	54	18	54		353	38
39	Building Service Equip-Hood Exhaust System	2009	2,011	134	15	134		871	39
40	Building Service Equip-HVAC Unit	2009	2,758		5			2,758	40
41	Building Service Equip-Electric Auto Doors	2009	8,873	888	10	888		5,767	41
42	Building Service Equip-Emergency Generator	2010	4,218	211	20	211		1,160	42
43	Building Service Equip-HVAC Units	2010	5,651	377	15	377		2,073	43
44	Building Service Equip-Waterheaters	2010	16,644	1,665	10	1,665		9,154	44
45	Land Improvements-Enclosure Gates	2010	2,551		3			2,551	45
46	Building Student Room Wallcovering, Flooring, Lighting	2011	2,881	169	17	169		762	46
47	Building Copier Power Supply	2011	1,004	56	18	56		252	47
48	Building-Dinning Room Flooring	2011	1,540	154	10	154		693	48
49	Building-Exit Lights	2011	1,155	77	15	77		347	49
50	Building-Wallcovering, Flooring, Lighting in Corridors	2011	77,025	4,531	17	4,531		20,389	50
51	Building-Day Room Flooring	2011	5,993	599	10	599		2,696	51
52	Building-Media Room Replacement Doors	2011	1,947	130	15	130		585	52
53	Building Service Equip-HVAC Replacement	2011	2,921	195	15	195		877	53
54	Building Service Equip-Kitchen Drain Line Replacement	2011	969	48	20	48		217	54
55	Building Service Equip-Emergency Generator Rebuild	2011	2,764	138	20	138		621	55
56	Building Service Equip-Partial Roof Replacement	2011	1,019	102	10	102		459	56
57	Building Service Equip-HVAC Replacement	2011	2,350	157	15	157		706	57
58	Building-Electrical Outlets	2011	2,688	149	18	149		522	58
59	Building-Sprinkler Heads	2012	8,360	334	25	334		1,169	59
60	Building-Electronic Door Closers	2012	1,275	85	15	85		298	60
61	Building-Smoke Detectors	2012	1,412	141	10	141		494	61
62	Building Service Equip-Generator Emergency Stops	2012	6,905	575	12	575		2,013	62
63	Building Service Equip-Generator Emergency Stops	2012	2,074	173	12	173		605	63
64	Building Service Equip-Dishwasher Electrical	2012	4,987	277	18	277		970	64
65	Building Service Equip-Pole Lighting	2012	3,003	200	15	200		700	65
66	Building Service Equip-Water Valves	2012	3,642	182	20	182		637	66
67									67
68	Land Improvements - Asphalt work, sealing, stripping and crack fi	2013	16,575	4,065	8	4,065		16,145	68
69	Building Service Equip - Carpet replacement in common area and	2013	12,886	2,259	18	2,259		5,648	69
70	TOTAL (lines 4 thru 69)		$ 14,548,356	$ 318,565		$ 318,565	$	$ 6,452,833	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: 01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 318,565		$ 318,565	$	$ 6,452,833	1
2	Building Service Equip - Suites kitchen ceiling tile replacement	2013	5,239	524	10	524		1,310	2
3	Building Service Equip - duct insulation in suites J, K halls and kit	2013	18,390	920	20	920		2,299	3
4	Building Service Equip - Replacement of courtyard doors and new	2013	3,766	286	15	286		715	4
5	Building Service Equip - Installation of Conduit to patient room ar	2013	4,245	225	20	225		564	5
6	Building Service Equip - Replace side roof HVAC Unit	2013	14,492	1,449	10	1,449		3,623	6
7	Building Service Equip - Replace power supply and celing fans in c	2013	2,299	151	18	151		377	7
8	Building Service Equip - Replace water heaters and repaired water	2013	20,271	1,893	25	1,893		4,733	8
9	Building Service Equip - TV's for skilled and intermediate commor	2013	6,185	1,237	5	1,237		3,093	9
10									10
11	Building Service Equip - Remodel of bathroom in F101 Frozen pip	2014	11,369	669	17	669		1,003	11
12	Building Service Equip - circuit board replacement for emergency	2014	9,641	803	12	803		1,205	12
13	Building Service Equip - Replacement controls and upgrade board	2014	5,602	450	15	450		675	13
14	Building Service Equip - Smoke detection & annunciator fire alarn	2014	85,705	8,571	10	8,571		12,856	14
15	Building Service Equip - Remodel of 5 bathrooms and storage area	2014	30,000	1,765	17	1,765		2,647	15
16	Building Service Equip - Electrical express locks of suites main ent	2014	6,160	616	10	616		924	16
17	Building Service Equip - Replacement of electronics for suites nurs	2014	4,704	470	10	470		705	17
18									18
19	Building - Replacement of circuit boards in	2015	4,653	155	15	155		155	19
20	rooftop HVAC unit								20
21	Buildings - Drywall repair in F102	2015	4,350	109	20	109		109	21
22	Building - Replacement of rooftop HVAC	2015	24,014	800	15	800		800	22
23	Buildings - Watermain repair throughout facility	2015	9,572	239	20	239		239	23
24	Bldg Svc Eq - Bathroom plumbing, flooring, paint, etc throughout	2015	36,277	1,067	17	1,067		1,067	24
25									25
26	To Reconcile to book depreciation			45,849			(45,849)		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,855,290	$ 386,813		$ 340,964	$ (45,849)	$ 6,491,932	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: 01/01/2015 Ending: 12/31/2015

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	$ 3,777,681	$ 240,268	$ 240,268	$	3-20	$ 2,534,146	71
72	Current Year Purchases	35,326	2,371	2,371		4-20	2,371	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 3,813,007	$ 242,639	$ 242,639	$		$ 2,536,517	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)	$ 19,554,297	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 629,452	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 583,603	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (45,849)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,028,449	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	Construction in Progress	$ 6,301	92
93			93
94			94
95		$ 6,301	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: 01/01/2015 Ending: 12/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 40,883 Description: Bed Rental: $29,376. CPM Machine Rental: $11,507.
    (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: 01/01/2015 Ending: 12/31/2015

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

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

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: 01/01/2015 Ending: 12/31/2015

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	$	14,115	$ 822,406	$	14,115	$ 822,406	1
2	Licensed Speech and Language Development Therapist	L39 C3	hrs		6,919	362,456		6,919	362,456	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39 C3	hrs		23,666	1,280,132		23,666	1,280,132	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					54,535		54,535	12
13	Other (specify):									13
14	TOTAL			$	44,700	$ 2,464,994	$ 54,535	44,700	$ 2,519,529	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 Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,974,778	$ 1,974,778	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 365,818)	2,343,082	2,343,082	3
4	Supply Inventory (priced at)	9,416	9,416	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	42,155	42,155	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,369,431	$ 4,369,431	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	13,176,169	12,281,185	14
15	Leasehold Improvements, at Historical Cost	1,690,594	2,574,105	15
16	Equipment, at Historical Cost	3,813,007	3,813,007	16
17	Accumulated Depreciation (book methods)	(9,024,593)	(9,028,449)	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	17,314,502	17,314,502	22
23	Other(specify): Trustee held assets	1,050,523	1,050,523	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 28,020,202	$ 28,890,873	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 32,389,633	$ 33,260,304	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 359,124	$ 359,124	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	307,092	307,092	29
30	Accrued Salaries Payable	754,843	754,843	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,167	13,167	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	68,925	68,925	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See SCH 17A	(3,760)	(3,760)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,499,391	$ 1,499,391	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	8,510,925	8,510,925	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Third Party	8,120,935	8,120,935	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 16,631,860	$ 16,631,860	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 18,131,251	$ 18,131,251	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 14,258,382	$ 15,129,053	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 32,389,633	$ 33,260,304	48

*(See instructions.)

Facility Name: **Miller Health Care Center**
IDPH License ID Number: **0040659**
Fiscal Year End: **12/31/2015**

Schedule 17A

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

	Description	Operating	After Consolidation
6-1037-1105	Bond Issue Costs,1994 Bond Issue Costs	1,907	1,907
6-1037-1120	Bond Issue Costs,2004 Bond Issue Costs	(9)	(9)
6-1037-1135	Bond Issue Costs,2009 Bond Issue Costs	117,101	117,101
6-1037-1145	Bond Issue Costs,2015 Bond Issue Costs	2,884	2,884
6-1047-1402	Const in Process,Nurse Call Light System	6,301	6,301
6-1050-0820	Due From Third Party,Due From SLC	17,186,318	17,186,318
6-1050-0845	Due From Third Party,Due From Medicare	0	0
	Total - Line 22	**17,314,502**	**17,314,502**

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

	Description	Operating	After Consolidation
6-1215-1604	Salary & Deductions,Pension Pay - GW	73,803	73,803
6-1215-1608	Salary & Deductions,Life Dep Disab	51,730	51,730
6-1215-1614	Salary & Deductions,General Wellness	(94)	(94)
6-1215-1620	Salary & Deductions,Trust Mark	211	211
6-1215-1621	Salary & Deductions,Occidental Life	(18,377)	(18,377)
6-1215-1622	Salary & Deductions,United Way Pay	62	62
6-1215-1623	Salary & Deductions,Hlth & Fitness	(5,527)	(5,527)
6-1215-1624	Salary & Deductions,Samaritan	0	0
6-1215-1625	Salary & Deductions,Lead With Your Heart	387	387
6-1215-1626	Salary & Deductions,Hosp Bill	0	0
6-1215-1627	Salary & Deductions,Day Care Pay	(200)	(200)
6-1215-1628	Salary & Deductions,Garn	28,701	28,701

6-1215-1630	Salary & Deductions,Gift Shop Pay	0	0
6-1215-1631	Salary & Deductions,Personal Deduct	268	268
6-1215-1632	Salary & Deductions,Nursing Excellence	(23)	(23)
6-1215-1633	Salary & Deductions,RN License Renewal	840	840
6-1215-1634	Salary & Deductions,Family Pharmacy	0	0
6-1215-1635	Salary & Deductions,RHE Uniform Ded	0	0
6-1215-1637	Salary & Deductions,Vendor Fair	(145)	(145)
6-1215-1638	Salary & Deductions,Noncash Cr Acct	(3,767)	(3,767)
6-1220-1730	Accrued Expenses,Public Aid Tax	(131,629)	(131,629)
6-1220-1735	Accrued Expenses,Other	0	0
	Total - Line 36	**(3,760)**	**(3,760)**

Facility Name & ID Number Miller Health Care Center **#** 0040659 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,363,858	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,363,858	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,894,524	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)**	$ 1,894,524	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)**	$ 14,258,382	24	*

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,311,889	1
2	Discounts and Allowances for all Levels	(6,290,145)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,021,744	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,780,198	6
7	Oxygen	1,890	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,782,088	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	26,658	13
14	Non-Patient Meals	52,907	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	800,970	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	688,850	19
20	Radiology and X-Ray	128,640	20
21	Other Medical Services	(27,020)	21
22	Laundry	12,928	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,683,933	23
	D. Non-Operating Revenue		
24	Contributions	889	24
25	Interest and Other Investment Income***	5,551	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,440	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See SCH 19A	65,766	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 65,766	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,559,971	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,817,790	31
32	Health Care	6,225,856	32
33	General Administration	2,399,435	33
	B. Capital Expense		
34	Ownership	1,113,423	34
	C. Ancillary Expense		
35	Special Cost Centers	2,882,791	35
36	Provider Participation Fee	226,152	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,665,447	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,894,524	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,894,524	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 217,640	44
45	Private Pay - Net Inpatient Revenue	4,706,709	45
46	Medicare - Net Inpatient Revenue	(902,605)	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,021,744	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.**

^ - Entity is a cash basis taxpayer

Facility Name: **Miller Health Care Center**
IDPH License ID Number: **0040659**
Fiscal Year End: **12/31/2015**

Schedule 19A

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

	Description	Amount
6-3000-3224	Admin,Misc Rev	19,504
6-3000-7805	Admin,Derivative Valuation	6,256
6-3000-7835	Admin,Trustee Restr	16,415
6-3000-7840	Admin,Trustee Realized G/L	23,591
	Total - Line 28	**65,766**

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,074	2,410	$ 144,279	$ 59.87	1
2	Assistant Director of Nursing	1,822	2,025	73,190	36.14	2
3	Registered Nurses	61,678	69,478	2,147,377	30.91	3
4	Licensed Practical Nurses	32,727	36,325	819,536	22.56	4
5	CNAs & Orderlies	106,373	115,575	1,365,230	11.81	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	13,240	14,547	240,318	16.52	10
11	Social Service Workers	4,020	4,417	79,459	17.99	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	44,815	47,718	513,378	10.76	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	243	250	6,346	25.38	17
18	Housekeepers	15,772	23,307	239,509	10.28	18
19	Laundry	0	0	0		19
20	Administrator	1,958	2,106	175,298	83.24	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	31,340	34,828	444,489	12.76	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify) Admissions Co-orc	13,069	14,175	312,767	22.06	33
34	TOTAL (lines 1 - 33)	329,131	367,161	$ 6,561,176 *	$ 17.87	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	391	$ 13,860	1(3)	35
36	Medical Director	Monthly	9,000	9(7)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,267	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)	391	$ 35,127		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: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Penny Varnavas	Administrator	0	$ 175,298
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 175,298

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	$ 62,589
Unemployment Compensation Insurance	
FICA Taxes	481,671
Employee Health Insurance	815,364
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	157,303
Dental Insurance	17,635
Disability Ins	13,730
Gainshare/Incentive	2,425
Employee Life Insurance	20,106
Reclassed to Sch V Ln 27	(90,564)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,480,259

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	
Health Care Worker Background Check	
(Indicate # of checks performed 127)	1,270
Patient Background Checks 755	7,550
Leading Age Illinois	12,000
Realias Learning, LLC	630
Miscellaneous Dues	2,615
Non-Allowable Dues	(4,320)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,745

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,109
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,109

**See instructions.

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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. **LeadingAge IL - 12,000**

(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? **4-20**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,465** 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. $ **226,152**
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. $ **52,907**

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.