FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 Trl (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 01/01/2016 to 12/31/2016 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: 01/01/2016 Ending: 12/31/2016

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	40,260	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,560	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		9,277	20,609	29,886	8
9	SNF/PED					9
10	ICF	2,481	14,098		16,579	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,481	23,375	20,609	46,465	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.35%

D. How many bed-hold days during this year were paid by the Department?
0 (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 20,609

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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	570,371	49,139	49,394	668,904		668,904		668,904			1
2	Food Purchase		360,137		360,137		360,137	(58,961)	301,176			2
3	Housekeeping	190,351	71,997	90,006	352,354		352,354		352,354			3
4	Laundry											4
5	Heat and Other Utilities			295,103	295,103		295,103		295,103			5
6	Maintenance	84,996	11,353	150,141	246,490		246,490		246,490			6
7	Other (specify):*											7
8	TOTAL General Services	845,718	492,626	584,644	1,922,988		1,922,988	(58,961)	1,864,027			8
	B. Health Care and Programs											
9	Medical Director							11,575	11,575			9
10	Nursing and Medical Records	5,329,313	999,181	209,618	6,538,112		6,538,112	(23,703)	6,514,409			10
10a	Therapy											10a
11	Activities	247,984	7,550	10,892	266,426		266,426		266,426			11
12	Social Services	109,703			109,703		109,703		109,703			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,687,000	1,006,731	220,510	6,914,241		6,914,241	(12,128)	6,902,113			16
	C. General Administration											
17	Administrative	118,003			118,003		118,003		118,003			17
18	Directors Fees											18
19	Professional Services											19
20	Dues, Fees, Subscriptions & Promotions			12,733	12,733		12,733	5,704	18,437			20
21	Clerical & General Office Expenses	401,894	27,263	168,702	597,859		597,859	2,424,498	3,022,357			21
22	Employee Benefits & Payroll Taxes			1,743,167	1,743,167		1,743,167	(104,475)	1,638,692			22
23	Inservice Training & Education							330	330			23
24	Travel and Seminar			10,591	10,591		10,591	(1,365)	9,226			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,568	72,568		72,568		72,568			26
27	Other (specify):* Mgmt. Co Benefits							120,006	120,006			27
28	TOTAL General Administration	519,897	27,263	2,007,761	2,554,921		2,554,921	2,444,698	4,999,619			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,052,615	1,526,620	2,812,915	11,392,150		11,392,150	2,373,609	13,765,759			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: 01/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			560,263	560,263		560,263	(842)	559,421			30
31	Amortization of Pre-Op. & Org.			9,571	9,571		9,571		9,571			31
32	Interest			453,419	453,419		453,419	(25,739)	427,680			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles							48,234	48,234			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,023,253	1,023,253		1,023,253	21,653	1,044,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		69,909	2,430,014	2,499,923		2,499,923	(36,106)	2,463,817			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			244,063	244,063		244,063		244,063			42
43	Other (specify):* Non-Allowable Cos			1,202,196	1,202,196		1,202,196	(1,202,196)				43
44	**TOTAL Special Cost Centers**		69,909	3,876,273	3,946,182		3,946,182	(1,238,302)	2,707,880			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,052,615	1,596,529	7,712,441	16,361,585		16,361,585	1,156,960	17,518,545			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: 01/01/2016 Ending: 12/31/2016

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	(59,056)	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				8
9	Non-Straightline Depreciation	(842)	30		9
10	Interest and Other Investment Income	(25,739)	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	(200,000)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(1,008,756)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,294,393)		$	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)	2,451,353		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,451,353		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,156,960		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: 01/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Cable	$ (7,834)	43	1
2	Offset unrealized gain/loss	16,673	6	2
3	Non-Allowable Lobbying Fee	(2,251)	20	3
4	Offset miscellaneous income	(12,092)	21	4
5	Offset loss on refunding	(994,362)	43	5
6	Offset derivative valuation	(8,890)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,008,756)		49

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 75,083	Riverside Medical Center		$ 75,083	$	1
2	V	10	Med Supplies and Medication	58,723	Oakside Corporation		58,723		2
3	V	10	Purchased Services	273,640	Riverside Medical Center		273,640		3
4	V	17	Administrator salary	75,238	Riverside Medical Center		75,238		4
5	V	21	Administrative services	12,000	Riverside Medical Center		2,447,822	2,435,822	5
6	V	21	Employee drug testing	4,800	Riverside Medical Center		4,800		6
7	V	22	Benefits	104,475	Riverside Medical Center			(104,475)	7
8	V	27	Benefits		Riverside Medical Center		120,006	120,006	8
9	V	39	Therapy Services	24,889	Riverside Medical Center		24,889		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 628,848			$ 3,080,201	$ * 2,451,353	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: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Directors							1
2								2
3	Bruce Fitzpatrick							3
4	Maggie Frogge							4
5	Kathy Gagliano							5
6	David Hegg, M.D.	Chairman						6
7	Claudette Hemenover							7
8	Mardene Hinton							8
9	Linda Mitchell, Ed.D.	Secretary						9
10	Keith Moss, M.D.							10
11	Phillip Kambic	President						11
12	Bruce Payne	Vice Chairman						12
13	Joy Rose							13
14	Norman Strasma							14
15	Dave Tyson							15
16	Bill Douglas	Treasurer						16
17	Pamela Hull	Asst. Secretary						17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 Page 6-Supplemental for 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: 01/01/2016 Ending: 2/31/2016

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		$ 75,083	$	1	$ 75,083	1
2	10	Med Supplies and Medication	Cost	1		58,723		1	58,723	2
3	10	Purchased Services	Cost	1		273,640		1	273,640	3
4	17	Administrator salary	Cost	1		75,238	75,238	1	75,238	4
5	21	Administrative services	Cost	239,341,117		38,124,278	117,637,732	15,367,228	2,447,822	5
6	21	Employee drug testing	Cost	1		4,800		1	4,800	6
7	27	Benefits	Cost	1		120,006		1	120,006	7
8	39	Therapy Services	Cost	1		24,889		1	24,889	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					$ 38,756,657	$ 117,712,970		$ 3,080,201	25

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 954,245	2019	Var	$ 6,689	1
2	Bond-2009	X		Partial Refinancing of 2004 bonds		2009	9,594,258	2,858,874	2035	0.0600	386,651	2
3	Bond-2015	X		Direct Replacement		2015	388,674	365,276	2029	Var	18,549	3
4	Bond-2016	X		Refund 2006C and partial refunding 2009 bonds		2016	4,565,589	4,983,753	11/15/2045	0.0327	41,530	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 19,700,521	$ 9,162,148			$ 453,419	9
	B. Non-Facility Related*											
10												10
11												11
12								Offset Interest Income			(25,739)	12
13												13
14	TOTAL Non-Facility Related						$ -	$			$ (25,739)	14
15	TOTALS (line 9+line14)						$ 19,700,521	$ 9,162,148			$ 427,680	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: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	2015	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 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.)**		$	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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Miller Healthcare Center COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0040659

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Not-for- profit organization no real e		$	$
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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

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).

Riverside Medical Center - 325 bed hospital
Butterfield Court - Assisted Living Facility
Westwood Oaks / Westwood Estates - Independent Living Facility

Total campus including the SNF is 13.26 acres or 577,605.60 square feet.

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: 01/01/2016 Ending: 12/31/2016

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	$ 50,986	44	$ 50,986	$	$ 2,555,212	4
5	10		1999	1999	656,641	14,834	30	14,834		603,859	5
6	10		2001	2001	147,085	31	15	31		147,085	6
7	40		2009	2009	7,937,516	185,867	44	185,867		1,424,814	7
8											8
	Improvement Type**										
9	Land Improvements			1995	63,411					63,411	9
10	Building Service Equipment			1995	1,295,587	9,068	25	9,068		1,203,254	10
11	Land Improvements-Landscaping			1997	4,688					4,688	11
12	Land Improvements-Walkways			1998	15,388					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	62	18	62		1,008	16
17	Land Improvements-Landscaping			2001	16,069	209		209		16,069	17
18	Building Service Equipment-HVAC			2001	2,551	127		127		1,977	18
19	Land Improvements-Courtyard Concrete			2002	640	32		32		464	19
20	Building Service Equipment-HVAC/Water Heater			2002	9,547	145		145		9,474	20
21	Building Service Equipment-HVAC/Water Heater			2003	5,003	124		124		4,818	21
22	Land Improvements-Gazebo			2004	510	26		26		319	22
23	Building Service Equip-waterline/sprinkler system revision			2004	8,208	259		259		5,783	23
24	Building-Carpeting/wallcoverings/lighting			2004	94,121					94,121	24
25	Building-Carpeting/wallcoverings/painting/ceiling tile			2005	205,826					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	332		332		6,974	27
28	Building-cabinets/doors/wall coverings			2006	131,916	1,979		1,979		124,424	28
29	Building Service Equipment-HVAC/electrical/plumbing			2006	22,864	1,299		1,299		15,437	29
30	Building-Physical Therapy renovation			2007	21,417	1,664		1,664		15,814	30
31	Building Service Equipment-Fire Alarm Upgrade			2007	6,448	562		562		5,342	31
32	Land Improvements-Pergola and landscaping			2008	15,903	1,517		1,517		12,895	32
33	Building-Carpeting/wallcoverings/lighting			2008	56,241	3,045		3,045		51,270	33
34	Building Service Equip-Sprinkler/electrical/HVAC/plumbing			2008	28,343	1,387		1,387		12,778	34
35	Building Service Equip-Lighting Fixtures			2009	3,718	371		371		2,789	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: 01/01/2016 Ending: 12/31/2016

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	$	$ 607	37
38	Building Service Equip-Back-up Generator	2009	980	54	18	54		408	38
39	Building Service Equip-Hood Exhaust System	2009	2,011	134	15	134		1,005	39
40	Building Service Equip-HVAC Unit	2009	2,758		5			2,758	40
41	Building Service Equip-Electric Auto Doors	2009	8,873	887	10	887		6,654	41
42	Building Service Equip-Emergency Generator	2010	4,218	211	20	211		1,371	42
43	Building Service Equip-HVAC Units	2010	5,651	377	15	377		2,450	43
44	Building Service Equip-Waterheaters	2010	16,644	1,664	10	1,664		10,818	44
45	Land Improvements-Enclosure Gates	2010	2,551					2,551	45
46	Building Student Room Wallcovering, Flooring, Lighting	2011	2,881	170	17	170		932	46
47	Building Copier Power Supply	2011	1,004	56	18	56		308	47
48	Building-Dinning Room Flooring	2011	1,540	154	10	154		847	48
49	Building-Exit Lights	2011	1,155	77	15	77		424	49
50	Building-Wallcovering, Flooring, Lighting in Corridors	2011	77,025	4,531	17	4,531		24,920	50
51	Building-Day Room Flooring	2011	5,993	599	10	599		3,295	51
52	Building-Media Room Replacement Doors	2011	1,947	130	15	130		715	52
53	Building Service Equip-HVAC Replacement	2011	2,921	195	15	195		1,072	53
54	Building Service Equip-Kitchen Drain Line Replacement	2011	969	49	20	49		266	54
55	Building Service Equip-Emergency Generator Rebuild	2011	2,764	138	20	138		759	55
56	Building Service Equip-Partial Roof Replacement	2011	1,019	102	10	102		561	56
57	Building Service Equip-HVAC Replacement	2011	2,350	157	15	157		863	57
58	Building-Electrical Outlets	2011	2,688	149	18	149		671	58
59	Building-Sprinkler Heads	2012	8,360	334	25	334		1,503	59
60	Building-Electronic Door Closers	2012	1,275	85	15	85		383	60
61	Building-Smoke Detectors	2012	1,412	141	10	141		635	61
62	Building Service Equip-Generator Emergency Stops	2012	6,905	576	12	576		2,589	62
63	Building Service Equip-Generator Emergency Stops	2012	2,074	173	12	173		778	63
64	Building Service Equip-Dishwasher Electrical	2012	4,987	277	18	277		1,247	64
65	Building Service Equip-Pole Lighting	2012	3,003	200	15	200		900	65
66	Building Service Equip-Water Valves	2012	3,642	182	20	182		819	66
67									67
68	Land Improvements - Asphalt work, sealing, stripping and crack f	2013	16,575	78	8	78		16,223	68
69	Building Service Equip - Carpet replacement in common area and	2013	12,886	2,259	18	2,259		7,907	69
70	TOTAL (lines 4 thru 69)		$ 14,548,356	$ 288,146		$ 288,146	$	$ 6,740,980	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: 01/01/2016 Ending: 12/31/2016

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	$ 288,146		$ 288,146	$	$ 6,740,980	1
2	Building Service Equip - Suites kitchen ceiling tile replacement	2013	5,239	524	10	524		1,834	2
3	Building Service Equip - duct insulation in suites J, K halls and ki	2013	18,390	919	20	919		3,218	3
4	Building Service Equip - Replacement of courtyard doors and nev	2013	3,766	286	15	286		1,001	4
5	Building Service Equip - Installation of Conduit to patient room a	2013	4,245	226	20	226		790	5
6	Building Service Equip - Replace side roof HVAC Unit	2013	14,492	1,449	10	1,449		5,072	6
7	Building Service Equip - Replace power supply and celing fans in	2013	2,299	151	18	151		528	7
8	Building Service Equip - Replace water heaters and repaired wate	2013	20,271	1,893	25	1,893		6,626	8
9	Building Service Equip - TV's for skilled and intermediate commo	2013	6,185	1,237	5	1,237		4,330	9
10									10
11	Building Service Equip - Remodel of bathroom in F101 Frozen pip	2014	11,369	669	17	669		1,672	11
12	Building Service Equip - circuit board replacement for emergency	2014	9,641	803	12	803		2,008	12
13	Building Service Equip - Replacement controls and upgrade board	2014	5,602	450	15	450		1,125	13
14	Building Service Equip - Smoke detection & annunciator fire alarr	2014	85,705	8,570	10	8,570		21,426	14
15	Building Service Equip - Remodel of 5 bathrooms and storage area	2014	30,000	1,765	17	1,765		4,412	15
16	Building Service Equip - Electrical express locks of suites main ent	2014	6,160	616	10	616		1,540	16
17	Building Service Equip - Replacement of electronics for suites nurs	2014	4,704	470	10	470		1,175	17
18									18
19	Building - Replacement of circuit boards in	2015	4,653	310	15	310		465	19
20	rooftop HVAC unit								20
21	Buildings - Drywall repair in F102	2015	4,350	217	20	217		326	21
22	Building - Replacement of rooftop HVAC	2015	24,014	1,601	15	1,601		2,401	22
23	Buildings - Watermain repair throughout facility	2015	9,572	479	20	479		718	23
24	Bldg Svc Eq - Bathroom plumbing, flooring, paint, etc throughout	2015	36,277	2,134	17	2,134		3,201	24
25									25
26	Building Service Equip - Miller Landscape - Courtyard Center of	2016	7,373	369	10	369		369	26
27	Building Service Equip - Concrete - Courtyard Center of Building	2016	8,500	283	15	283		283	27
28	Building Service Equip - Nurse Call System - Throughout the Buil	2016	6,301	315	10	315		315	28
29	Building Service Equip - Grease Trap Kitchen	2016	23,770	1,189	10	1,189		1,189	29
30	Building Service Equip - Painting Rooms 102,3,4,5,6,8,9,10	2016	22,780	2,278	5	2,278		2,278	30
31	Building Service Equip - Exterior Painting Old Side	2016	29,133	2,913	5	2,913		2,913	31
32	Building Service Equip - Transfer Switch Mechanical Rm	2016	20,086	2,009	5	2,009		2,009	32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,973,233	$ 322,271		$ 322,271	$	$ 6,814,204	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: 01/01/2016 Ending: 12/31/2016

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 12B, Carried Forward		$ 14,973,233	$ 322,271		$ 322,271	$	$ 6,814,204	1
2	Building Service Equip - Fire Dampers - Throughout the Building	2016	36,690	1,835	10	1,835		1,835	2
3	Building Service Equip - Rubber Roof Replacement	2016	327,910	16,396	10	16,396		16,396	3
4	Building Service Equip - Replace 5 - 7.5 Ton RTU & Exhaust Fan	2016	24,222	807	15	807		750	4
5	Building Service Equip - New Cooling RTU Electrical Rm	2016	17,000	567	15	567		567	5
6	Building Service Equip - Sliding Door - North Entrance	2016	9,927	496	10	496		496	6
7									7
8									8
9									9
10									10
11									11
12									12
13	To Reconcile to Book Depreciation			842			(842)		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 15,388,982	$ 343,214		$ 342,372	$ (842)	$ 6,834,248	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: 01/01/2016 Ending: 12/31/2016

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	$ 2,906,083	$ 210,217	$ 210,217	$ -	3-20	$ 1,839,809	71
72	Current Year Purchases	79,838	6,832	6,832	-	3-12	6,832	72
73	Fully Depreciated Assets	906,925			-	3-20	906,925	73
74					-			74
75	TOTALS	$ 3,892,846	$ 217,049	$ 217,049	$ -		$ 2,753,566	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)	$ 20,167,828	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 560,263	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 559,421	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (842)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,587,814	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: 01/01/2016 Ending: 12/31/2016

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

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 48,234 Description: Bed Rental: $36,106. CPM Machine Rental: $12,128.
(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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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	$	13,058	$ 779,807	$	13,058	$ 779,807	1
2	Licensed Speech and Language Development Therapist	L39 C3	hrs		6,325	339,599		6,325	339,599	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39 C3	hrs		22,773	1,262,598		22,773	1,262,598	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					33,803		33,803	12
13	Other (specify):									13
14	TOTAL			$	42,156	$ 2,382,004	$ 33,803	42,156	$ 2,415,807	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:** 01/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 2,148,593	$ 2,148,593	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 568,854)	2,365,461	2,365,461	3
4	Supply Inventory (priced at)	12,966	12,966	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	21,321	21,321	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,548,341	$ 4,548,341	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	12,927,862	12,281,185	14
15	Leasehold Improvements, at Historical Cost	1,319,039	3,107,797	15
16	Equipment, at Historical Cost	2,995,846	3,892,846	16
17	Accumulated Depreciation (book methods)	(7,539,485)	(9,587,814)	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 (spe See SCH 17A	22,673,823	22,673,823	22
23	Other(specify): Trustee held assets	695,568	695,568	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 33,072,653	$ 33,949,405	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 37,620,994	$ 38,497,746	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 348,448	$ 348,448	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	395,481	395,481	29
30	Accrued Salaries Payable	798,765	798,765	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,145	13,145	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	57,051	57,051	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See SCH 17A	277,921	277,921	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,890,811	$ 1,890,811	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	8,766,667	8,766,667	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Third Party	13,285,475	13,285,475	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 22,052,142	$ 22,052,142	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 23,942,953	$ 23,942,953	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,678,041	$ 14,554,793	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 37,620,994	$ 38,497,746	48

***(See instructions.)**

Facility Name: **Miller Health Care Center**
IDPH License ID Number: **0040659**
Fiscal Year End: **12/31/2016**

Schedule 17A

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

Description	Operating	After Consolidation
Bond Issue Costs,1994 Bond Issue Costs	1,089	1,089
Bond Issue Costs,2004 Bond Issue Costs	(9)	(9)
Bond Issue Costs,2009 Bond Issue Costs	41,743	41,743
Bond Issue Costs,2015 Bond Issue Costs	2,387	2,387
Bond Issue Costs,2016 Bond Issue Costs	64,378	64,378
Const in Process,Miller Corridor Upgrades	93,773	93,773
Due From Third Party,Due From SLC	22,470,462	22,470,462
Total - Line 23	**22,673,823**	**22,673,823**

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

Description	Operating	After Consolidation
Salary & Deductions,Fed W/H & FICA	20,580	20,580
Salary & Deductions,Pension Pay - GW	84,696	84,696
Salary & Deductions,Life Dep Disab	49,902	49,902
Salary & Deductions,General Wellness	(21,196)	(21,196)
Salary & Deductions,Trust Mark	216	216
Salary & Deductions,Occidental Life	(18,378)	(18,378)
Salary & Deductions,Lead With Your Heart	729	729
Salary & Deductions,Garn	28,775	28,775
Salary & Deductions,Personal Deduct	1,843	1,843
Salary & Deductions,RN License Renewal	2,360	2,360
Salary & Deductions,Vendor Fair	(83)	(83)
Salary & Deductions,Noncash Cr Acct	(3,379)	(3,379)
Salary & Deductions,Health Savings Acct	9,595	9,595
Salary & Deductions,Employee Wellness	2,367	2,367
Accured Expenses,Accd Exp	250,000	250,000
Accrued Expenses,Public Aid Tax	(130,106)	(130,106)
Total - Line 36	**277,921**	**277,921**

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 14,258,382	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	2,137	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 14,260,519	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(582,478)	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)**	$ (582,478)	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)**	$ 13,678,041	24 *

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	$ 10,485,720	1
2	Discounts and Allowances for all Levels	(7,235,279)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,250,441	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,908,496	6
7	Oxygen	54	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,908,550	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	33,772	13
14	Non-Patient Meals	59,056	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	735,823	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	721,943	19
20	Radiology and X-Ray	3,686	20
21	Other Medical Services	15,140	21
22	Laundry	18,573	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,587,993	23
	D. Non-Operating Revenue		
24	Contributions	2,075	24
25	Interest and Other Investment Income***	25,739	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,814	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See SCH 19A	4,309	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,309	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,779,107	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,922,988	31
32	Health Care	6,914,241	32
33	General Administration	2,554,921	33
	B. Capital Expense		
34	Ownership	1,023,253	34
	C. Ancillary Expense		
35	Special Cost Centers	3,702,119	35
36	Provider Participation Fee	244,063	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,361,585	40
41	**Income before Income Taxes (line 30 minus line 40)****	(582,478)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (582,478)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 365,093	44
45	Private Pay - Net Inpatient Revenue	4,885,572	45
46	Medicare - Net Inpatient Revenue	(2,000,224)	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,250,441	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: **12/31/2016**

Schedule 19A

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

Description	Amount
Admin,Misc Rev	12,092
Admin,Derivative Valuation	8,890
Admin,Trustee Unrealized G/L	(16,673)
Total - Line 28	**4,309**

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	1,974	2,175	$ 140,302	$ 64.51	1
2	Assistant Director of Nursing	3,751	4,188	160,581	38.34	2
3	Registered Nurses	63,271	71,053	2,269,154	31.94	3
4	Licensed Practical Nurses	30,693	34,037	826,706	24.29	4
5	CNAs & Orderlies	116,677	126,568	1,564,392	12.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,002	2,175	44,579	20.50	9
10	Activity Assistants	10,339	11,421	203,405	17.81	10
11	Social Service Workers	4,393	5,021	109,703	21.85	11
12	Dietician	387	395	9,020	22.84	12
13	Food Service Supervisor	2,464	3,057	53,450	17.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	36,564	39,693	456,883	11.51	15
16	Dishwashers	4,176	5,196	51,018	9.82	16
17	Maintenance Workers	4,003	4,003	84,996	21.23	17
18	Housekeepers	18,828	18,828	190,351	10.11	18
19	Laundry					19
20	Administrator	1,340	1,675	118,003	70.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,515	18,909	401,894	21.25	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 C: Admissions	14,535	15,507	368,178	23.74	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	332,912	363,901	$ 7,052,615 *	$ 19.38	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	792	$ 27,703	1(3)	35
36	Medical Director	Monthly	11,575	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	1,501	48,010	39(3)	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)	2,293	$ 99,555		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		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: 01/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Penny Varnavas	Administrator	0	$ 42,765
Jamee O'Brien	Administrator	0	75,238
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 118,003

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	$ 69,357
Unemployment Compensation Insurance	
FICA Taxes	499,488
Employee Health Insurance	922,103
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	188,338
Dental Insurance	20,781
Disability Ins	16,553
Gainshare/Incentive	75
Employee Life Insurance	24,466
Admin/Pro Fees-Benefits	2,006
Reclassed to Sch V Ln 27	(104,475)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,638,692

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 53)	530
Patient Background Checks 660	6,600
LeadingAge Illinois	11,254
Miscellaneous Dues	2,304
Non-Allowable Dues	(2,251)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,437

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	9,226
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,226

**See instructions.

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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 - $11,254**

(3) Did the nursing home make political contributions or payments to a politica
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? **3-12 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **38,412** 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 fo
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
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **244,063**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **59,056**

(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 fo
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