FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 Healthcare Center

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

County: Kankakee

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/18 to 12/31/18 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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		6,679	19,209	25,888	8
9	SNF/PED					9
10	ICF	3,103	12,737		15,840	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,103	19,416	19,209	41,728	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.45%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 19,209

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	578,281	34,275	84,258	696,814		696,814	-	696,814			1
2	Food Purchase		353,183		353,183		353,183	(41,145)	312,038			2
3	Housekeeping	210,002	42,534	136,507	389,043		389,043	-	389,043			3
4	Laundry	-	-	-				-				4
5	Heat and Other Utilities			272,534	272,534		272,534	-	272,534			5
6	Maintenance	84,998	7,728	173,940	266,666		266,666	-	266,666			6
7	Other (specify):*	-	-	-				-				7
8	**TOTAL General Services**	873,281	437,720	667,239	1,978,240		1,978,240	(41,145)	1,937,095			8
	B. Health Care and Programs											
9	Medical Director	-	-	-				-				9
10	Nursing and Medical Records	5,306,552	1,100,131	195,943	6,602,626		6,602,626	(5,403)	6,597,223			10
10a	Therapy	-	-	-				-				10a
11	Activities	296,242	6,562	9,255	312,059		312,059	-	312,059			11
12	Social Services	100,099	-	-	100,099		100,099	-	100,099			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):*	-	-	-				-				15
16	**TOTAL Health Care and Programs**	5,702,893	1,106,693	205,198	7,014,784		7,014,784	(5,403)	7,009,381			16
	C. General Administration											
17	Administrative	148,952	-	-	148,952		148,952	-	148,952			17
18	Directors Fees			-				-				18
19	Professional Services			-				-				19
20	Dues, Fees, Subscriptions & Promotions			14,070	14,070		14,070	8,641	22,711			20
21	Clerical & General Office Expenses	429,836	17,226	147,568	594,630		594,630	2,204,219	2,798,849			21
22	Employee Benefits & Payroll Taxes			1,863,421	1,863,421		1,863,421	(110,066)	1,753,355			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			2,880	2,880		2,880	129	3,009			24
25	Other Admin. Staff Transportation		-	-				-				25
26	Insurance-Prop.Liab.Malpractice			74,679	74,679		74,679	-	74,679			26
27	Other (specify):* Mgmt. Co Benefits	-	-	-				131,599	131,599			27
28	**TOTAL General Administration**	578,788	17,226	2,102,618	2,698,632		2,698,632	2,234,522	4,933,154			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,154,962	1,561,639	2,975,055	11,691,656		11,691,656	2,187,974	13,879,630			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 Healthcare Center #0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			638,668	638,668		638,668	(1,050)	637,618			30
31	Amortization of Pre-Op. & Org.			7,118	7,118		7,118	-	7,118			31
32	Interest			350,693	350,693		350,693	(17,692)	333,001			32
33	Real Estate Taxes			-				-				33
34	Rent-Facility & Grounds			-				-				34
35	Rent-Equipment & Vehicles			1,757	1,757		1,757	56,676	58,433			35
36	Other (specify):*			-				-				36
37	TOTAL Ownership			998,236	998,236		998,236	37,934	1,036,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	47,987	2,071,896	2,119,883		2,119,883	(21,030)	2,098,853			39
40	Barber and Beauty Shops	-	-	-				-				40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			223,389	223,389		223,389	-	223,389			42
43	Other (specify):* Non-Allowable Cos	-	-	19,747	19,747		19,747	(19,747)				43
44	TOTAL Special Cost Centers		47,987	2,315,032	2,363,019		2,363,019	(40,777)	2,322,242			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,154,962	1,609,626	6,288,323	15,052,911		15,052,911	2,185,131	17,238,042			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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(41,145)	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	(1,050)	30		9
10	Interest and Other Investment Income	(17,692)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(108)	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 PG5A	(38,452)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (98,447)		$	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)	2,283,578		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,283,578		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 2,185,131		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 Healthcare Center

ID# 0040659

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Cable	$ (6,195)	43	1
2	Offset realized gain/loss	(13,444)	6	2
3	Non-Allowable Lobbying Fee	(840)	20	3
4	Offset miscellaneous income	(5,952)	21	4
5	Offset derivative valuation	(25,365)	21	5
6	Offset to rental account	13,344	35	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
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32				32
33				33
34				34
35				35
36				36
37				37
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(38,452)		49

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 79,227	Riverside Medical Center		$ 79,227	$	1
2	V	10	Med Supplies and Medication	30,604	Oakside Corporation		30,604		2
3	V	10	Purchased Services	443,188	Riverside Medical Center		443,188		3
4	V	17	Administrator salary	165,842	Riverside Medical Center		165,842		4
5	V	21	Administrative services	12,000	Riverside Medical Center		2,274,045	2,262,045	5
6	V	21	Employee drug testing	4,800	Riverside Medical Center		4,800		6
7	V	22	Benefits	110,066	Riverside Medical Center			(110,066)	7
8	V	27	Benefits		Riverside Medical Center		131,599	131,599	8
9	V	39	Therapy Services	30,373	Riverside Medical Center		30,373		9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 876,100			$ 3,159,678	$ * 2,283,578	14

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

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.							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	Chairman						12
13	Joy Rose							13
14	Norman Strasma							14
15	Dave Tyson	Vice Chairman						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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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					$		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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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		$ 79,227	$	1	$ 79,227	1
2	10	Med Supplies and Medication	Cost	1		30,604		1	30,604	2
3	10	Purchased Services	Cost	1		443,188		1	443,188	3
4	17	Administrator salary	Cost	1		165,842		1	165,842	4
5	21	Administrative services	Cost	284,149,356		42,964,854	134,796,995	15,039,465	2,274,045	5
6	21	Employee drug testing	Cost	1		4,800		1	4,800	6
7	27	Benefits	Cost	1		131,599		1	131,599	7
8	39	Therapy Services	Cost	1		30,373		1	30,373	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					$ 43,850,487	$ 134,796,995		$ 3,159,678	25

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bond-2009	X		Partial Refinancing of 2004 bon		2009	$ 9,594,258	$ 2,861,831	2035	0.0600	$ 181,912	1
2	Bond-2015	X		Direct Replacement		2015	388,674	59,758	2029	Var	9,561	2
3	Bond-2016	X		Refund 2006C and partial refun		2016	4,565,589	4,777,579	11/15/1945	0.0327	159,220	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 14,548,521	$ 7,699,168			$ 350,693	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(17,692)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (17,692)	14
15	TOTALS (line 9+line14)						$ 14,548,521	$ 7,699,168			$ 333,001	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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)	2017	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2018 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.)**	Alloc Fr. Mgmt 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:			
	2013	N/A	8
	2014		9
	2015		10
	2016		11
	2017		12

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 - 96 beds
Westwood Oaks / Westwood Estates - Independent Living Facility - 90 beds

Total campus including the SNF is 13.26 acrea 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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 2,657,180	4
5	10		1999	1999	656,641	11,093	30	11,093		627908	5
6	10		2001	2001	147,085	-	15	-		147085	6
7	40		2009	2009	7,937,516	185,867	44	185,867		1796549	7
8						-		-			8
	Improvement Type**										
9	Land Improvements		1995	1995	63,411	-		-		63,411	9
10	Building Service Equipment		1995	1995	1,295,587	9,068	25	9,068		1,221,390	10
11	Land Improvements-Landscaping		1997	1997	4,688	-		-		4,688	11
12	Land Improvements-Walkways		1998	1998	15,388	-		-		15,388	12
13	Building-Carpeting		1998	1998	2,370	-		-		2,370	13
14	Land Improvements-Landscaping and pond dec		1999	1999	25,379	-		-		25,379	14
15	Building-Carpeting		2000	2000	3,125	-		-		3,125	15
16	Building Service Equipment-Exterior Lighting		2000	2000	1,100	31	18	31		1,100	16
17	Land Improvements-Landscaping		2001	2001	16,069	-		-		16,069	17
18	Building Service Equipment-HVAC		2001	2001	2,551	127		127		2,232	18
19	Land Improvements-Courtyard Concrete		2002	2002	640	32		32		528	19
20	Building Service Equipment-HVAC/Water Heater		2002	2002	9,547					9,547	20
21	Building Service Equipment-HVAC/Water Heater		2003	2003	5,003	62		62		5,003	21
22	Land Improvements-Gazebo		2004	2004	510	26		26		370	22
23	Building Service Equip-waterline/sprinkler system revision		2004	2004	8,208	258		258		6,300	23
24	Building-Carpeting/wallcoverings/lighting		2004	2004	94,121	-		-		94,121	24
25	Building-Carpeting/wallcoverings/painting/ceiling tile		2005	2005	205,826	-		-		205,826	25
26	Land Improvements-Asphalt walkway		2005	2005	7,574	-		-		7,574	26
27	Building Service Equip-water heater/generator/doors/compr		2005	2005	8,142	332		332		7,641	27
28	Building-cabinets/doors/wall coverings		2006	2006	131,916	1,665		1,665		127,754	28
29	Building Service Equipment-HVAC/electrical/plumbing		2006	2006	22,864	1,110		1,110		17,658	29
30	Building-Physical Therapy renovation		2007	2007	21,417	682		682		17,669	30
31	Building Service Equipment-Fire Alarm Upgrade		2007	2007	6,448	90		90		5,759	31
32	Land Improvements-Pergola and landscaping		2008	2008	15,903	832		832		15,244	32
33	Building-Carpeting/wallcoverings/lighting		2008	2008	56,241	1,562		1,562		55,880	33
34	Building Service Equip-Sprinkler/electrical/HVAC/plumbing		2008	2008	28,343	1,387		1,387		15,554	34
35	Building Service Equip-Lighting Fixtures		2009	2009	3,718	371		371		3,532	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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	$ 769	37
38	Building Service Equip-Back-up Generator	2009	980	55	18	55		517	38
39	Building Service Equip-Hood Exhaust System	2009	2,011	134	15	134		1,273	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		8,429	41
42	Building Service Equip-Emergency Generator	2010	4,218	211	20	211		1,793	42
43	Building Service Equip-HVAC Units	2010	5,651	377	15	377		3,204	43
44	Building Service Equip-Waterheaters	2010	16,644	1,664	10	1,664		14,147	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		1,271	46
47	Building Copier Power Supply	2011	1,004	56	18	56		420	47
48	Building-Dinning Room Flooring	2011	1,540	154	10	154		1,155	48
49	Building-Exit Lights	2011	1,155	77	15	77		578	49
50	Building-Wallcovering, Flooring, Lighting in Corridors	2011	77,025	4,531	17	4,531		33,982	50
51	Building-Day Room Flooring	2011	5,993	599	10	599		4,494	51
52	Building-Media Room Replacement Doors	2011	1,947	130	15	130		975	52
53	Building Service Equip-HVAC Replacement	2011	2,921	195	15	195		1,462	53
54	Building Service Equip-Kitchen Drain Line Replacement	2011	969	49	20	49		363	54
55	Building Service Equip-Emergency Generator Rebuild	2011	2,764	138	20	138		1,035	55
56	Building Service Equip-Partial Roof Replacement	2011	1,019	102	10	102		765	56
57	Building Service Equip-HVAC Replacement	2011	2,350	156	15	156		1,176	57
58	Building-Electrical Outlets	2011	2,688	149	18	149		969	58
59	Building-Sprinkler Heads	2012	8,360	335	25	335		2,172	59
60	Building-Electronic Door Closers	2012	1,275	85	15	85		553	60
61	Building-Smoke Detectors	2012	1,412	141	10	141		917	61
62	Building Service Equip-Generator Emergency Stops	2012	6,905	576	12	576		3,740	62
63	Building Service Equip-Generator Emergency Stops	2012	2,074	173	12	173		1,124	63
64	Building Service Equip-Dishwasher Electrical	2012	4,987	277	18	277		1,801	64
65	Building Service Equip-Pole Lighting	2012	3,003	200	15	200		1,300	65
66	Building Service Equip-Water Valves	2012	3,642	182	20	182		1,183	66
67				-		-			67
68	Land Improvements - Asphalt work, sealing, stripping and crack f	2013	16,575	78	8	78		16,379	68
69	Building Service Equip - Carpet replacement in common area and	2013	12,886	1,191	18	1,191		11,357	69
70	TOTAL (lines 4 thru 69)		$ 14,548,356	$ 278,734		$ 278,734	$	$ 7,304,446	70

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

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 278,734		$ 278,734	$	$ 7,304,446	1
2	Building Service Equip - Suites kitchen ceiling tile replacement	2013	5,239	524	10	524		2,882	2
3	Building Service Equip - duct insulation in suites J, K halls and ki	2013	18,390	919	20	919		5,057	3
4	Building Service Equip - Replacement of courtyard doors and nev	2013	3,766	286	15	286		1,572	4
5	Building Service Equip - Installation of Conduit to patient room a	2013	4,245	226	20	226		1,241	5
6	Building Service Equip - Replace side roof HVAC Unit	2013	14,492	1,449	10	1,449		7,970	6
7	Building Service Equip - Replace power supply and celing fans in	2013	2,299	151	18	151		830	7
8	Building Service Equip - Replace water heaters and repaired wate	2013	20,271	1,893	25	1,893		10,412	8
9	Building Service Equip - TV's for skilled and intermediate commo	2013	6,185	618	5	618		6,185	9
10				-		-			10
11	Building Service Equip - Remodel of bathroom in F101 Frozen pip	2014	11,369	669	17	669		3,010	11
12	Building Service Equip - circuit board replacement for emergency	2014	9,641	804	12	804		3,615	12
13	Building Service Equip - Replacement controls and upgrade board	2014	5,602	449	15	449		2,023	13
14	Building Service Equip - Smoke detection & annunciator fire aları	2014	85,705	8,570	10	8,570		38,567	14
15	Building Service Equip - Remodel of 5 bathrooms and storage area	2014	30,000	1,765	17	1,765		7,942	15
16	Building Service Equip - Electrical express locks of suites main ent	2014	6,160	616	10	616		2,772	16
17	Building Service Equip - Replacement of electronics for suites nur	2014	4,704	470	10	470		2,116	17
18				-		-			18
19	Building - Replacement of circuit boards in	2015	4,653	310	15	310		1,085	19
20	rooftop HVAC unit			-		-			20
21	Buildings - Drywall repair in F102	2015	4,350	217	20	217		761	21
22	Building - Replacement of rooftop HVAC	2015	24,014	1,600	15	1,600		5,602	22
23	Buildings - Watermain repair throughout facility	2015	9,572	479	20	479		1,676	23
24	Bldg Svc Eq - Bathroom plumbing, flooring, paint, etc throughout	2015	36,277	2,134	17	2,134		7,469	24
25				-		-			25
26	Building Service Equip - Miller Landscape - Courtyard Center of	2016	7,373	737	10	737		1,843	26
27	Building Service Equip - Concrete - Courtyard Center of Building	2016	8,500	567	15	567		1,417	27
28	Building Service Equip - Nurse Call System - Throughout the Buil	2016	6,301	630	10	630		1,575	28
29	Building Service Equip - Grease Trap Kitchen	2016	23,770	2,377	10	2,377		5,943	29
30	Building Service Equip - Painting Rooms 102,3,4,5,6,8,9,10	2016	22,780	4,556	5	4,556		11,390	30
31	Building Service Equip - Exterior Painting Old Side	2016	29,133	5,827	5	5,827		14,567	31
32	Building Service Equip - Transfer Switch Mechanical Rm	2016	20,086	4,017	5	4,017		10,043	32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 14,973,233	$ 321,594		$ 321,594	$	$ 7,464,011	34

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

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 321,594		$ 321,594	$	$ 7,464,011	1
2	Building Service Equip - Fire Dampers - Throughout the Building	2016	36,690	3,669	10	3,669		9,173	2
3	Building Service Equip - Rubber Roof Replacement	2016	327,910	32,791	10	32,791		81,978	3
4	Building Service Equip - Replace 5 - 7.5 Ton RTU & Exhaust Fan	2016	24,222	1,615	15	1,615		4,037	4
5	Building Service Equip - New Cooling RTU Electrical Rm	2016	17,000	1,133	15	1,133		2,833	5
6	Building Service Equip - Sliding Door - North Entrance	2016	9,927	993	10	993		2,482	6
7				-		-			7
8	Building Service Equip - Courtyard Plant Installation	2017	19,500	1,950	10	1,950		2,925	8
9	Building Service Equip - Corridors E, D and H Refinishing	2017	556,854	32,756	17	32,756		49,134	9
10	-wall coverings, paint, flooring, hand rails, nurses			-		-			10
11	stations and lighting			-		-			11
12	Building Service Equip - 3 Roof Top Units	2017	36,000	1,800	20	1,800		2,700	12
13				-		-			13
14	Building Services Equip - Landscape W Courtyard & Drip Irrigat	2018	23,500	1,175	10	1,175		1,175	14
15	Building Services Equip - New hot steam wells & countertops	2018	545,527	27,276	10	27,276		27,276	15
16	-including new electrical wiring. Replaced flooring & wall								16
17	-coverings - G Hall Dining Room			-		-			17
18	Building Services Equip - South entrance door replacement	2018	12,000	600	10	600		600	18
19				-		-			19
20	To Reconcile to Book Depreciation			1,050		-	(1,050)		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)		$ 16,582,363	$ 428,402		$ 427,352	$ (1,050)	$ 7,648,324	34

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

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 2,284,479	$ 202,697	$ 202,697	$ -	5-15	$ 1,388,981	71
72	Current Year Purchases	130,094	7,569	7,569	-	5-15	7,569	72
73	Fully Depreciated Assets	869,217			-		869,217	73
74					-			74
75	TOTALS	$ 3,283,790	$ 210,266	$ 210,266	$		$ 2,265,767	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)	$ 20,752,153	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 638,668	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 637,618	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,050)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,914,091	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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 58,433 Description: Bed Rental: $51,273. CPM Machine Rental: $5,403. Therapy Equipment: $1,757
(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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$	11,873	$ 750,016	$	11,873	$ 750,016	1
2	Licensed Speech and Language Development Therapist	L39 C3	hrs		4,188	237,731		4,188	237,731	2
3	Licensed Recreational Therapist	L39 C3 & C7	hrs		2,097	66,309		2,097	66,309	3
4	Licensed Physical Therapist	L39 C3	hrs		17,643	1,034,739		17,643	1,034,739	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	L39 C2					10,058		10,058	12
13	Other (specify): Respiratory Therapy	L39 C3 & C7								13
14	TOTAL			$	35,801	$ 2,088,795	$ 10,058	35,801	$ 2,098,853	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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 1,538,448	$ 1,538,448	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 247,742)	1,652,797	1,652,797	3
4	Supply Inventory (priced at)	8,715	8,715	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	32,157	32,157	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,232,117	$ 3,232,117	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	14,078,243	12,281,185	14
15	Leasehold Improvements, at Historical Cost	1,362,039	4,301,178	15
16	Equipment, at Historical Cost	3,293,714	3,283,790	16
17	Accumulated Depreciation (book methods)	(8,774,730)	(9,914,091)	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	19,927,997	19,927,997	22
23	Other(specify): Trustee held assets	714,012	714,012	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 30,601,275	$ 31,480,071	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 33,833,392	$ 34,712,188	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 267,315	$ 267,315	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	114,587	114,587	29
30	Accrued Salaries Payable	980,409	980,409	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	55,679	55,679	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See SCH 17A	385,253	385,253	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,803,243	$ 1,803,243	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	7,584,581	7,584,581	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Third Party	11,112,219	11,112,219	43
44	Change in FV of Derivative	21,809	21,809	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 18,718,609	$ 18,718,609	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 20,521,852	$ 20,521,852	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,311,540	$ 14,190,336	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 33,833,392	$ 34,712,188	48

***(See instructions.)**

Facility Name: **Miller Healthcare Center**
IDPH License ID Number: **0040659**
Fiscal Year End: **12/31/18**

Schedule 17A

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

	Description	Operating	After Consolidation
6-1037-1135	Bond Issue Costs,2009 Bond Issue Costs	36,832	36,832
6-1037-1145	Bond Issue Costs,2015 Bond Issue Costs	1,451	1,451
6-1037-1150	Bond Issue Costs,2016 Bond Issue Costs	56,131	56,131
6-1047-1401	Const in Process,Current Constr.	8,275	8,275
6-1050-0820	Due From Third Party,Due From SLC	19,825,288	19,825,288
6-1215-1622	Salary & Deductions,United Way Pay	20	20
	Total - Line 22	**19,927,997**	**19,927,997**

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

	Description	Operating	After Consolidation
6-1215-1602	Salary & Deductions,Fed W/H & FICA	23,524	23,524
6-1215-1603	Salary & Deductions,IL W/H Pay	(6,186)	(6,186)
6-1215-1604	Salary & Deductions,Pension Pay - GW	97,307	97,307
6-1215-1608	Salary & Deductions,Life Dep Disab	41,106	41,106
6-1215-1614	Salary & Deductions,General Wellness	(29,776)	(29,776)
6-1215-1620	Salary & Deductions,Trust Mark	1,289	1,289
6-1215-1621	Salary & Deductions,Occidental Life	(16,041)	(16,041)
6-1215-1624	Salary & Deductions,Samaritan	-	-
6-1215-1625	Salary & Deductions,Lead With Your Hea	786	786
6-1215-1626	Salary & Deductions,Hosp Bill	-	-
6-1215-1627	Salary & Deductions,Day Care Pay	264	264
6-1215-1628	Salary & Deductions,Garn	30,598	30,598
6-1215-1630	Salary & Deductions,Gift Shop Pay	-	-
6-1215-1631	Salary & Deductions,Personal Deduct	1,843	1,843
6-1215-1632	Salary & Deductions,Nursing Excellence	3,183	3,183
6-1215-1633	Salary & Deductions,RN License Renewal	3,080	3,080
6-1215-1634	Salary & Deductions,Family Pharmacy	-	-
6-1215-1635	Salary & Deductions,RHE Uniform Ded	-	-
6-1215-1637	Salary & Deductions,Vendor Fair	206	206
6-1215-1638	Salary & Deductions,Noncash Cr Acct	(6,001)	(6,001)
6-1215-1639	Salary & Deductions,Health Savings Acct	78,100	78,100
6-1215-1640	Salary & Deductions,MetLife	(390)	(390)
6-1215-1641	Salary & Deductions,Employee Wellness	3,328	3,328
6-1220-1700	Accrued Expenses,Accd Exp	296,496	296,496
6-1220-1730	Accrued Expenses,Public Aid Tax	(137,463)	(137,463)
	Total - Line 36	**385,253**	**385,253**

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,713,540	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(22,743)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 13,690,797	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(379,257)	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) **Rounding**		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (379,257)	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)**	$ 13,311,540	24 *

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

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	$ 9,906,327	1
2	Discounts and Allowances for all Levels	(6,177,343)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,728,984	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,556,050	6
7	Oxygen	29	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,556,079	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	37,298	13
14	Non-Patient Meals	41,145	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	898,373	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	322,272	19
20	Radiology and X-Ray		20
21	Other Medical Services	26,751	21
22	Laundry	12,715	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,338,554	23
	D. Non-Operating Revenue		
24	Contributions	1,028	24
25	Interest and Other Investment Income***	17,692	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,720	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See SCH 19A	31,317	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,317	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,673,654	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,978,240	31
32	Health Care	7,014,784	32
33	General Administration	2,698,632	33
	B. Capital Expense		
34	Ownership	998,236	34
	C. Ancillary Expense		
35	Special Cost Centers	2,139,630	35
36	Provider Participation Fee	223,389	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,052,911	40
41	**Income before Income Taxes (line 30 minus line 40)****	(379,257)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (379,257)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 520,454	44
45	Private Pay - Net Inpatient Revenue	4,516,887	45
46	Medicare - Net Inpatient Revenue	(1,308,357)	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,728,984	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 Healthcare Center**
IDPH License ID Number: **0040659**
Fiscal Year End: **12/31/18**

Schedule 19A

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

	Description	Amount
6-3000-3224	Admin,Misc Rev	5,952
6-3000-7805	Admin,Derivative Valuation	25,365
	Total - Line 28	**31,317**

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	1,899	2,184	$ 151,583	$ 69.41	1
2	Assistant Director of Nursing	3,484	4,067	166,549	40.95	2
3	Registered Nurses	59,465	64,965	2,238,965	34.46	3
4	Licensed Practical Nurses	22,907	26,477	713,536	26.95	4
5	CNAs & Orderlies	102,272	111,756	1,641,404	14.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,870	2,184	52,872	24.21	9
10	Activity Assistants	11,318	12,529	243,370	19.42	10
11	Social Service Workers	4,390	4,785	100,099	20.92	11
12	Dietician					12
13	Food Service Supervisor	5,967	6,591	139,049	21.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,886	31,910	390,909	12.25	15
16	Dishwashers	4,057	4,421	48,323	10.93	16
17	Maintenance Workers	4,028	4,028	84,998	21.10	17
18	Housekeepers	20,772	20,772	210,002	10.11	18
19	Laundry					19
20	Administrator	1,653	1,886	148,952	78.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,576	17,647	429,836	24.36	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:					32
33	Other(specify) Admissions	14,535	15,507	394,515	25.44	33
34	TOTAL (lines 1 - 33)	303,079	331,709	$ 7,154,962 *	$ 21.57	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		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,199	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)		$ 11,199		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 Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jamee O'Brien	Administrator	0	$ 148,952
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 148,952

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	$ 77,523
Unemployment Compensation Insurance	
FICA Taxes	490,727
Employee Health Insurance	1,021,314
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	219,480
Dental Insurance	12,997
Disability Ins	15,607
Gainshare/Incentive	
Employee Life Insurance	24,618
Admin/Pro Fees-Benefits	1,155
Reclassed to Sch V Ln 27	(110,066)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,753,355

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 961)	
Patient Background Checks	9,610
LeadingAge Illinois	6,000
Allscripts	3,995
Miscellaneous Dues	1,956
Non-Allowable Dues	(840)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,711

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,009
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,009

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 - $6,000**

(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? **N/A**

(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? **5-15 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **49,847** 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.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **223,389**
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? **No** Indicate the amount. $ **41145**

(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.