FOR BHF USE							

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0040659

Facility Name: Miller Health Care Center

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

County: Kankakee

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

HFS ID Number:

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

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 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: 01/01/20 Ending: 12/31/20

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,103	3,268	13,483	17,854	8
9	SNF/PED					9
10	ICF	3,083	8,523		11,606	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,186	11,791	13,483	29,460	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.31%

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 13,483

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: 12/31/2020 Fiscal Year: 12/31/2020

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

STATE OF ILLINOIS

Facility Name & ID Number Miller Health Care Center # 0040659 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

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	401,175	33,749	71,549	506,473		506,473		506,473			1
2	Food Purchase		273,394		273,394		273,394	(18,494)	254,900			2
3	Housekeeping	246,819	45,547	83,108	375,474		375,474		375,474			3
4	Laundry	-	-	-								4
5	Heat and Other Utilities			220,065	220,065		220,065		220,065			5
6	Maintenance	85,000	780	127,491	213,271		213,271		213,271			6
7	Other (specify):*	-	-	-								7
8	**TOTAL General Services**	732,994	353,470	502,213	1,588,677		1,588,677	(18,494)	1,570,183			8
	B. Health Care and Programs											
9	Medical Director	-	-	-				24,525	24,525			9
10	Nursing and Medical Records	4,453,561	792,491	258,134	5,504,186		5,504,186	(25,057)	5,479,129			10
10a	Therapy	-	-	-								10a
11	Activities	236,522	4,929	2,571	244,022		244,022		244,022			11
12	Social Services	89,798	-	-	89,798		89,798		89,798			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	**TOTAL Health Care and Programs**	4,779,881	797,420	260,705	5,838,006		5,838,006	(532)	5,837,474			16
	C. General Administration											
17	Administrative	121,156	-	-	121,156		121,156		121,156			17
18	Directors Fees			-								18
19	Professional Services			-								19
20	Dues, Fees, Subscriptions & Promotions			5,434	5,434		5,434	5,360	10,794			20
21	Clerical & General Office Expenses	288,442	6,280	349,407	644,129		644,129	1,755,619	2,399,748			21
22	Employee Benefits & Payroll Taxes			1,655,498	1,655,498		1,655,498	(83,202)	1,572,296			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			1,056	1,056		1,056		1,056			24
25	Other Admin. Staff Transportation		-	-								25
26	Insurance-Prop.Liab.Malpractice			87,428	87,428		87,428		87,428			26
27	Other (specify):* **Mgmt. Co Benefits**			-				87,188	87,188			27
28	**TOTAL General Administration**	409,598	6,280	2,098,823	2,514,701		2,514,701	1,764,965	4,279,666			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,922,473	1,157,170	2,861,741	9,941,384		9,941,384	1,745,939	11,687,323			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: 01/01/20 Ending: 12/31/20

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			716,197	716,197		716,197	41,233	757,430			30
31	Amortization of Pre-Op. & Org.			4,334	4,334		4,334		4,334			31
32	Interest			155,557	155,557		155,557	(187)	155,370			32
33	Real Estate Taxes			-								33
34	Rent-Facility & Grounds			-								34
35	Rent-Equipment & Vehicles			-				46,882	46,882			35
36	Other (specify):*			-								36
37	TOTAL Ownership			876,088	876,088		876,088	87,928	964,016			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	55,276	1,308,297	1,363,573		1,363,573	(46,350)	1,317,223			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			189,391	189,391		189,391		189,391			42
43	Other (specify):* Non-Allowable Co	224,848	-	2,698	227,546		227,546	(227,546)				43
44	TOTAL Special Cost Centers	224,848	55,276	1,500,386	1,780,510		1,780,510	(273,896)	1,506,614			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,147,321	1,212,446	5,238,215	12,597,982		12,597,982	1,559,971	14,157,953			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: 01/01/20 Ending: 12/31/20

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	(18,494)	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	41,233	30		9
10	Interest and Other Investment Income	(187)	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				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	(232,110)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (209,558)		$	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)	1,769,529		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,769,529		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,559,971		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

STATE OF ILLINOIS

Miller Health Care Center

ID# 0040659

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset cable TV expense	$ (1,619)	43	1
2	Offset Admin, Realized Gain	(1,079)	43	2
3	Offset miscellaneous income	(1,107)	21	3
4	Offset unrealized gain/loss	(3,457)	21	4
5	Offset Admissions Salary	(224,848)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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**	(232,110)		49

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	N/A		Riverside Medical Cer	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	$ 60,237	Riverside Medical Center		$ 60,237	$	1
2	V	10	Med Supplies and Medication	239	Oakside Corporation		239		2
3	V	10	Purchased Services	396,405	Riverside Medical Center		396,405		3
4	V	17	Administrator salary	121,156	Riverside Medical Center		121,156		4
5	V	21	Administrative services	12,000	Riverside Medical Center		1,777,543	1,765,543	5
6	V	21	Employee drug testing	4,800	Riverside Medical Center		4,800		6
7	V	22	Benefits	83,202	Riverside Medical Center			(83,202)	7
8	V	22	Benefits		Riverside Medical Center		87,188	87,188	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 678,039			$ 2,447,568	$ * 1,769,529	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: 01/01/20 Ending: 12/31/20

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	Mardene Hinton							7
8	Linda Mitchell, Ed.D.	Secretary						8
9	Keith Moss, M.D.							9
10	Phillip Kambic	President						10
11	Bruce Payne	Chairman						11
12	Joy Rose							12
13	Norman Strasma							13
14	Dave Tyson	Vice Chairman						14
15	Bill Douglas	Treasurer						15
16	Pamela Hull	Asst. Secretary						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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Health Care Center # 0040659 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 60,237	$	1	$ 60,237	1
2	10	Med Supplies and Medication	Cost	1		239		1	239	2
3	10	Purchased Services	Cost	1		396,405		1	396,405	3
4	17	Administrator salary	Cost	1		121,156		1	121,156	4
5	21	Administrative services	Cost	317,588,464		44,814,769	165,196,513	12,596,902	1,777,543	5
6	21	Employee drug testing	Cost	1		4,800		1	4,800	6
7	27	Benefits	Cost	1		87,188		1	87,188	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	TOTALS					$ 45,484,794	$ 165,196,513		$ 2,447,568	25

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/20 Ending: 12/31/20

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-2015	X		Direct Replacement		2015	$ 388,674	$ 15,815	2029	Var	$ 3,608	1
2	Bond-2016	X		Refund 2006C and partial refunding 2009 bonds		2016	4,565,589	4,534,403	11/15/2045	0.0327	151,949	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 4,954,263	$ 4,550,218			$ 155,557	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(187)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (187)	14
15	TOTALS (line 9+line14)						$ 4,954,263	$ 4,550,218			$ 155,370	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: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Line	Description	Amount	
	1. Real Estate Tax accrual used on 2019 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.) **2019**	$	2
	3. Under or (over) accrual (line 2 minus line 1).	$	3
	4. Real Estate Tax accrual used for 2020 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
	Alloc. Fr. Mgmt. Co. 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:		
2015		8
2016		9
2017		10
2018		11
2019		12

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIOI	$	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.

2019 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 2019 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 2019.

	(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? N/A 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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

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 Health Care Center # 0040659 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$	$ 2,759,152	4
5	10		1999	1999	656,641	11,093	30	11,093		650,094	5
6	10		2001	2001	147,085		15			147,085	6
7	40		2009	2009	7,937,516	185,867	44	185,867		2,168,283	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		1,239,526	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 decl			1999	25,379					25,379	14
15	Building-Carpeting			2000	3,125					3,125	15
16	Building Service Equipment-Exterior Lighting			2000	1,100					1,100	16
17	Land Improvements-Landscaping			2001	16,069					16,069	17
18	Building Service Equipment-HVAC			2001	2,551	127		127		2,486	18
19	Land Improvements-Courtyard Concrete			2002	640	32		32		592	19
20	Building Service Equipment-HVAC/Water Heater			2002	9,547					9,547	20
21	Building Service Equipment-HVAC/Water Heater			2003	5,003					5,003	21
22	Land Improvements-Gazebo			2004	510	26		26		422	22
23	Building Service Equip-waterline/sprinkler system revision			2004	8,208	258		258		6,816	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		166	(166)	8,139	27
28	Building-cabinets/doors/wall coverings			2006	131,916	1,665		1,665		131,084	28
29	Building Service Equipment-HVAC/electrical/plumbing			2006	22,864	1,110		1,110		19,878	29
30	Building-Physical Therapy renovation			2007	21,417	682		682		19,033	30
31	Building Service Equipment-Fire Alarm Upgrade			2007	6,448	90		90		5,939	31
32	Land Improvements-Pergola and landscaping			2008	15,903	832			(832)	15,903	32
33	Building-Carpeting/wallcoverings/lighting			2008	56,241	1,562			(1,562)	56,241	33
34	Building Service Equip-Sprinkler/electrical/HVAC/plumbing			2008	28,343	1,387		1,387		18,328	34
35	Building Service Equip-Lighting Fixtures			2009	3,718	371			(371)	3,718	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: 01/01/20 Ending: 12/31/20

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	$	$ 931	37
38	Building Service Equip-Back-up Generator	2009	980	55	18	55		627	38
39	Building Service Equip-Hood Exhaust System	2009	2,011	134	15	134		1,541	39
40	Building Service Equip-HVAC Unit	2009	2,758					2,758	40
41	Building Service Equip-Electric Auto Doors	2009	8,873	887	10		(887)	8,873	41
42	Building Service Equip-Emergency Generator	2010	4,218	211	20	211		2,215	42
43	Building Service Equip-HVAC Units	2010	5,651	377	15	377		3,958	43
44	Building Service Equip-Waterheaters	2010	16,644	1,664	10	832	(832)	16,643	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		1,611	46
47	Building Copier Power Supply	2011	1,004	56	18	56		532	47
48	Building-Dinning Room Flooring	2011	1,540	154	10	154		1,463	48
49	Building-Exit Lights	2011	1,155	77	15	77		732	49
50	Building-Wallcovering, Flooring, Lighting in Corridors	2011	77,025	4,531	17	4,531		43,044	50
51	Building-Day Room Flooring	2011	5,993	599	10	599		5,692	51
52	Building-Media Room Replacement Doors	2011	1,947	130	15	130		1,235	52
53	Building Service Equip-HVAC Replacement	2011	2,921	195	15	195		1,852	53
54	Building Service Equip-Kitchen Drain Line Replacement	2011	969	49	20	49		461	54
55	Building Service Equip-Emergency Generator Rebuild	2011	2,764	138	20	138		1,311	55
56	Building Service Equip-Partial Roof Replacement	2011	1,019	102	10	102		969	56
57	Building Service Equip-HVAC Replacement	2011	2,350	156	15	156		1,488	57
58	Building-Electrical Outlets	2011	2,688	149	18	149		1,267	58
59	Building-Sprinkler Heads	2012	8,360	335	25	335		2,842	59
60	Building-Electronic Door Closers	2012	1,275	85	15	85		723	60
61	Building-Smoke Detectors	2012	1,412	141	10	141		1,199	61
62	Building Service Equip-Generator Emergency Stops	2012	6,905	576	12	576		4,892	62
63	Building Service Equip-Generator Emergency Stops	2012	2,074	173	12	173		1,470	63
64	Building Service Equip-Dishwasher Electrical	2012	4,987	277	18	277		2,355	64
65	Building Service Equip-Pole Lighting	2012	3,003	200	15	200		1,700	65
66	Building Service Equip-Water Valves	2012	3,642	182	20	182		1,547	66
67									67
68	Land Improvements - Asphalt work, sealing, stripping and crack fi	2013	16,575	78	8	78		16,535	68
69	Building Service Equip - Carpet replacement in common area and	2013	12,886	1,191	18	338	(853)	12,886	69
70	TOTAL (lines 4 thru 69)		$ 14,548,356	$ 278,641		$ 273,138	$ (5,503)	$ 7,854,223	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: 01/01/20 Ending: 12/31/20

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	$ 278,641		$ 273,138	$ (5,503)	$ 7,854,223	1
2	Building Service Equip - Suites kitchen ceiling tile replacement	2013	5,239	524	10	524		3,930	2
3	Building Service Equip - duct insulation in suites J, K halls and kit	2013	18,390	919	20	919		6,895	3
4	Building Service Equip - Replacement of courtyard doors and new	2013	3,766	286	15	251	(35)	2,109	4
5	Building Service Equip - Installation of Conduit to patient room ar	2013	4,245	226	20	212	(14)	1,679	5
6	Building Service Equip - Replace side roof HVAC Unit	2013	14,492	1,449	10	1,449		10,868	6
7	Building Service Equip - Replace power supply and celing fans in c	2013	2,299	151	18	128	(23)	1,109	7
8	Building Service Equip - Replace water heaters and repaired water	2013	20,271	1,893	25	811	(1,082)	13,116	8
9	Building Service Equip - TV's for skilled and intermediate common	2013	6,185					6,185	9
10									10
11	Building Service Equip - Remodel of bathroom in F101 Frozen pipe	2014	11,369	669	17	669		4,348	11
12	Building Service Equip - circuit board replacement for emergency t	2014	9,641	804	12	804		5,223	12
13	Building Service Equip - Replacement controls and upgrade boards	2014	5,602	449	15	373	(76)	2,845	13
14	Building Service Equip - Smoke detection & annunciator fire alarm	2014	85,705	8,570	10	8,570		55,707	14
15	Building Service Equip - Remodel of 5 bathrooms and storage area	2014	30,000	1,765	17	1,765		11,472	15
16	Building Service Equip - Electrical express locks of suites main entr	2014	6,160	616	10	616		4,004	16
17	Building Service Equip - Replacement of electronics for suites nurse	2014	4,704	470	10	470		3,056	17
18									18
19	Building - Replacement of circuit boards in	2015	4,653	310	15	310		1,705	19
20	rooftop HVAC unit								20
21	Buildings - Drywall repair in F102	2015	4,350	217	20	217		1,195	21
22	Building - Replacement of rooftop HVAC	2015	24,014	1,600	15	1,600		8,802	22
23	Buildings - Watermain repair throughout facility	2015	9,572	479	20	479		2,634	23
24	Bldg Svc Eq - Bathroom plumbing, flooring, paint, etc throughout f	2015	36,277	2,134	17	2,134		11,737	24
25									25
26	Building Service Equip - Miller Landscape - Courtyard Center of B	2016	7,373	737	10	737		3,317	26
27	Building Service Equip - Concrete - Courtyard Center of Building	2016	8,500	567	15	567		2,551	27
28	Building Service Equip - Nurse Call System - Throughout the Build	2016	6,301	630	10	630		2,835	28
29	Building Service Equip - Grease Trap Kitchen	2016	23,770	2,377	10	2,377		10,697	29
30	Building Service Equip - Painting Rooms 102,3,4,5,6,8,9,10	2016	22,780	4,556	5	4,556		20,502	30
31	Building Service Equip - Exterior Painting Old Side	2016	29,133	5,827	5	5,827		26,221	31
32	Building Service Equip - Transfer Switch Mechanical Rm	2016	20,086	4,017	5	4,017		18,077	32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,973,233	$ 320,883		$ 314,150	$ (6,733)	$ 8,097,042	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: 01/01/20 Ending: 12/31/20

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	$ 320,883		$ 314,150	$ (6,733)	$ 8,097,042	1
2	Building Service Equip - Fire Dampers - Throughout the Building	2016	36,690	3,669	10	3,669		16,511	2
3	Building Service Equip - Rubber Roof Replacement	2016	327,910	32,791	10	32,791		147,560	3
4	Building Service Equip - Replace 5 - 7.5 Ton RTU & Exhaust Fan	2016	24,222	1,615	15	1,615		7,267	4
5	Building Service Equip - New Cooling RTU Electrical Rm	2016	17,000	1,133	15	1,133		5,099	5
6	Building Service Equip - Sliding Door - North Entrance	2016	9,927	993	10	993		4,468	6
7									7
8	Building Service Equip - Courtyard Plant Installation	2017	19,500	1,950	10	1,950		6,825	8
9	Building Service Equip - Corridors E, D and H Refinishing	2017	556,854	32,756	17	32,756		114,646	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		6,300	12
13									13
14	Building Services Equip - Landscape W Courtyard & Drip Irrigati	2018	23,500	2,350	10	2,350		5,875	14
15	Building Services Equip - New hot steam wells & countertops	2018	545,527	54,553	10	54,553		136,382	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	1,200	10	1,200		3,000	18
19	Landscaping Trees plants mulch stone	2019	6,591	330	10	659	329	989	19
20	Trane rooftop unit miller D hall RTU	2019	16,550	552	15	1,104	552	1,655	20
21	Miller ceiling tiles in assisted kitchen	2019	9,791	612	8	1,224	612	1,836	21
22	Kitchen RTU replacement	2019	60,911	2,030	15	4,061	2,031	6,091	22
23	IDPH replace pendants and fire tape	2019	7,226	213	17	425	212	638	23
24	Patient room upgrades painting-paint door frames	2019	181,423	5,336	17	10,672	5,336	16,008	24
25	bathrooms, patching, spot stain								25
26	Water heater replacement-boiler room	2019	8,455	423	10	846	423	1,269	26
27	R&M Replace electronic board on boiler	2019	4,446		20	222	222	333	27
28									28
29	Pt Room Renovations Phase 2-Install fire alarm cabling, relays & p	2020	24,483	720	17	720		720	29
30	NW Svc Door & SW Main Entry & New doors at Employee Entrance								30
31	Replacement of Rooftop Unit in D Hall	2020	17,000	567	15	567		567	31
32	New Compressor for RTU unit	2020	4,076	102	20	102		102	32
33	Water Heater Replacement-Suites Hallway	2020	14,400	360	20	360		360	33
34	TOTAL (lines 1 thru 33)		$ 16,937,715	$ 466,938		$ 469,922	$ 2,984	$ 8,581,543	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: 01/01/20 Ending: 12/31/20

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 12C, Carried Forward		$ 16,937,715	$ 466,938		$ 469,922	$ 2,984	$ 8,581,543	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	To Reconcile to Book Depreciation			-38,249			38,249		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 16,937,715	$ 428,689		$ 469,922	$ 41,233	$ 8,581,543	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: 01/01/20 Ending: 12/31/20

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	$ 2,803,319	$ 275,767	$ 275,767	$	5-15	$ 1,919,118	71
72	Current Year Purchases	138,888	11,741	11,741		5-15	11,741	72
73	Fully Depreciated Assets	869,217					869,217	73
74								74
75	TOTALS	$ 3,811,424	$ 287,508	$ 287,508	$		$ 2,800,076	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)	$ 21,635,139	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 716,197	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 757,430	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 41,233	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 11,381,619	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	CIP	$ 7,414	92
93			93
94			94
95		$ 7,414	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 46,882 Description: $46,350 Bed Rental, $532 CPM Machine Rental
    (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: 01/01/20 Ending: 12/31/20

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.

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	$	8,116	$ 546,041	$	8,116	$ 546,041	1
2	Licensed Speech and Language Development Therapist	L39 C3	hrs		2,897	175,257		2,897	175,257	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39 C3	hrs		9,220	575,975		9,220	575,975	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 C3					8,926		8,926	12
13	Other (specify):									13
14	TOTAL			$	20,233	$ 1,297,272	$ 8,926	20,233	$ 1,306,198	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: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 3,397,829	$ 3,397,829	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 317,658)	1,529,409	1,529,409	3
4	Supply Inventory (priced at)	11,107	11,107	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	-	-	6
7	Other Prepaid Expenses	45,568	45,568	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify):	-	-	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,983,913	$ 4,983,913	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	14,390,184	12,281,185	14
15	Leasehold Improvements, at Historical Cost	1,351,740	4,656,530	15
16	Equipment, at Historical Cost	3,766,862	3,811,424	16
17	Accumulated Depreciation (book methods)	(10,038,016)	(11,381,619)	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	27,761,472	27,761,472	22
23	Other(specify):	-	-	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 37,232,242	$ 38,014,992	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 42,216,155	$ 42,998,905	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 209,425	$ 209,425	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	109,378	109,378	29
30	Accrued Salaries Payable	988,735	988,735	30
31	Accrued Taxes Payable (excluding real estate taxes)	-	-	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	-	32
33	Accrued Interest Payable	70,111	70,111	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See SCH 17A	1,843,786	1,843,786	36
37		-	-	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,221,435	$ 3,221,435	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	-	-	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	4,440,840	4,440,840	41
42	Deferred Compensation	-	-	42
	Other Long-Term Liabilities(specify):			
43	Due to Third Party	21,173,083	21,173,083	43
44	Change in FV of Derivative	17,483	17,483	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 25,631,406	$ 25,631,406	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 28,852,841	$ 28,852,841	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,363,314	$ 14,146,064	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 42,216,155	$ 42,998,905	48

*(See instructions.)

Facility Name: **Miller Health Care Center**
IDPH License ID Number: **0040659**
Fiscal Year End: **12/31/20**

Schedule 17A

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

Description	Operating	After Consolidation
Bond Issue Costs,2015 Bond Issue Costs	416	416
Bond Issue Costs,2016 Bond Issue Costs	48,188	48,188
Const In Process,Current Constr.	7,414	7,414
Due From Third Party,Due From Slc	27,704,745	27,704,745
Salary & Deductions,United Way Pay	709	709
Total - Line 22	**27,761,472**	**27,761,472**
	-	-

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Salary & Deductions,Fed W/H & Fica	363,074	363,074
Salary & Deductions,Il W/H Pay	(25,491)	(25,491)
Salary & Deductions,Pension Pay - Gw	97,409	97,409
Salary & Deductions,Life Dep Disab	74,522	74,522
Salary & Deductions,General Wellness	(29,776)	(29,776)
Salary & Deductions,Trust Mark	1,302	1,302
Salary & Deductions,Occidental Life	(11,343)	(11,343)
Salary & Deductions,Lead With Your Heart	50	50
Salary & Deductions,Garn	25,377	25,377
Salary & Deductions,Rn License Renewal	80	80
Salary & Deductions,Noncash Cr Acct	(13,837)	(13,837)
Salary & Deductions,Metlife	737	737
Salary & Deductions,Employee Wellness	25	25
Accrued Expenses,Accd Exp	331,496	331,496
Accrued Expenses,Public Aid Tax	(123,169)	(123,169)
Accrued Expenses,Other	1,153,330	1,153,330
Total - Line 36	**1,843,786**	**1,843,786**
	-	-

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 12,965,031	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 12,965,031	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	398,287	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	(4)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 398,283	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)**	$ 13,363,314	24 *

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,342,052	1
2	Discounts and Allowances for all Levels	(2,718,672)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,623,380	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	5,523,502	6
7	Oxygen	3,964	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,527,466	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,040,150	10
11	CNA Training Reimbursements	-	11
12	Gift and Coffee Shop	-	12
13	Barber and Beauty Care	6,393	13
14	Non-Patient Meals	18,494	14
15	Telephone, Television and Radio	-	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	580,841	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	165,020	19
20	Radiology and X-Ray	2,594	20
21	Other Medical Services	13,285	21
22	Laundry	13,895	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,840,672	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	187	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 187	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		-	28
28a	See SCH 19A	4,564	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,564	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,996,269	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,588,677	31
32	Health Care	5,838,006	32
33	General Administration	2,514,701	33
	B. Capital Expense		
34	Ownership	876,088	34
	C. Ancillary Expense		
35	Special Cost Centers	1,591,119	35
36	Provider Participation Fee	189,391	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,597,982	40
41	**Income before Income Taxes (line 30 minus line 40)****	398,287	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 398,287	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 662,509	44
45	Private Pay - Net Inpatient Revenue	2,874,162	45
46	Medicare - Net Inpatient Revenue	2,086,709	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,623,380	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: **12/31/20**

Schedule 19A

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

Description	Amount
Admin,Misc Rev	1,107
Admin,Derivative Valuation	3,457
Total - Line 28	**4,564**
	-

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,556	1,714	$ 81,908	$ 47.79	1
2	Assistant Director of Nursing	2,139	2,396	91,054	38.00	2
3	Registered Nurses	54,980	61,232	2,209,289	36.08	3
4	Licensed Practical Nurses	15,698	18,002	495,704	27.54	4
5	CNAs & Orderlies	84,779	93,438	1,575,606	16.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,969	2,199	56,794	25.83	9
10	Activity Assistants	6,978	8,100	179,728	22.19	10
11	Social Service Workers	3,086	3,478	89,798	25.82	11
12	Dietician					12
13	Food Service Supervisor	2,908	3,581	86,266	24.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,183	18,338	263,880	14.39	15
16	Dishwashers	3,908	4,094	51,029	12.46	16
17	Maintenance Workers	4,028	4,028	85,000	21.10	17
18	Housekeepers	24,413	24,413	246,819	10.11	18
19	Laundry					19
20	Administrator	1,520	1,890	121,156	64.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,617	8,842	288,442	32.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca					32
33	Other(specify) Admissions	6,718	7,606	224,848	29.56	33
34	TOTAL (lines 1 - 33)	239,480	263,351	$ 6,147,321 *	$ 23.34	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 68,800	1(3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,814	10(7)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	11,025	39(3)	42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,571	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 96,210		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	187	$ 9,647	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	187	$ 9,647		53

Facility Name & ID Number: Miller Health Care Center # 0040659 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Elizabeth Totheroh	Administrator	0	$ 121,156
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 121,156

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	$ 79,403
Unemployment Compensation Insurance	
FICA Taxes	427,038
Employee Health Insurance	900,210
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	178,651
Dental Insurance	14,898
Disability Ins	29,508
Gainshare/Incentive	2,370
Employee Life Insurance	23,420
Reclassed to Sch V Ln 27	(83,202)
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,572,296

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)		
Patient Background Checks	536	5,360
Allscripts		3,579
Miscellaneous Dues		1,855
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 10,794

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,056
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,056

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **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? ______

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **45,524** 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. $ **189,391**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **18,494**

(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.