



Facility Name & ID Number Miller Health Care Center

# 0040659 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

**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 \_\_\_\_\_

	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	70	Skilled (SNF)	70	25,620	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	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF		12,647	7,873	20,520	8
9	SNF/PED					9
10	ICF	3,251	13,940		17,191	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,251	26,587	7,873	37,711	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.86%

D. How many bed-hold days during this year were paid by Public Aid? 23 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) vending machines and guest/employee meals

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  NO

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

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  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 28 and days of care provided 7,873

Medicare Intermediary Mutual of Omaha

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

\* 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: 01/01/2004 Ending: 12/31/2004

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	274,939	128,787	13,565	417,291	(305)	416,986	(14,092)	402,894		1
2	Food Purchase		215,962		215,962		215,962		215,962		2
3	Housekeeping	120,564	29,554	60,041	210,159	(59,527)	150,632		150,632		3
4	Laundry					59,517	59,517	(18,740)	40,777		4
5	Heat and Other Utilities			124,425	124,425		124,425		124,425		5
6	Maintenance	59,834	4,341	64,017	128,192	(156)	128,036		128,036		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	455,337	378,644	262,048	1,096,029	(471)	1,095,558	(32,832)	1,062,726		8
<b>B. Health Care and Programs</b>											
9	Medical Director					446	446		446		9
10	Nursing and Medical Records	2,210,269	775,370	40,909	3,026,548	(1,664)	3,024,884	7,012	3,031,896		10
10a	Therapy		104	300,239	300,343	(750)	299,593	24,457	324,050		10a
11	Activities	86,990	3,213	2,880	93,083	(270)	92,813		92,813		11
12	Social Services	33,772	7		33,779		33,779		33,779		12
13	Nurse Aide Training										13
14	Program Transportation	19,701			19,701		19,701		19,701		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,350,732	778,694	344,028	3,473,454	(2,238)	3,471,216	31,469	3,502,685		16
<b>C. General Administration</b>											
17	Administrative	275,931		(40)	275,891		275,891	14,235	290,126		17
18	Directors Fees										18
19	Professional Services			1,474	1,474	(446)	1,028		1,028		19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	(1,843)	21,626	93,454	113,237	(4,497)	108,740	(42,743)	65,997		21
22	Employee Benefits & Payroll Taxes			1,059,579	1,059,579		1,059,579	45,704	1,105,283		22
23	Inservice Training & Education										23
24	Travel and Seminar					8,333	8,333		8,333		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			39,807	39,807		39,807		39,807		26
27	Other (specify):* <b>Admitting</b>	33,385	202	2,275	35,862	(681)	35,181		35,181		27
28	<b>TOTAL General Administration</b>	307,473	21,828	1,196,549	1,525,850	2,709	1,528,559	17,196	1,545,755		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,113,542	1,179,166	1,802,625	6,095,333		6,095,333	15,833	6,111,166		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 &amp; ID Number

Miller Health Care Center

#0040659

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			349,980	349,980		349,980		349,980			30
31	Amortization of Pre-Op. & Org.			4,439	4,439		4,439		4,439			31
32	Interest			91,024	91,024		91,024	(36,925)	54,099			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bond			28,046	28,046		28,046		28,046			36
37	<b>TOTAL Ownership</b>			473,489	473,489		473,489	(36,925)	436,564			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			19,425	19,425		19,425	(19,425)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			85,305	85,305		85,305	(19,425)	65,880			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,113,542	1,179,166	2,361,419	6,654,127		6,654,127	(40,517)	6,613,610			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: 01/01/2004

Ending: 12/31/2004

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,092)			4
5	Telephone, TV & Radio in Resident Rooms	(3,309)			5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(18,740)			8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(36,925)			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	(39,434)			24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (112,500)		\$	30

OHF 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	2	
		Amount	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)	1,202,544		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,202,544		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ 1,090,044		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops		X	19,424	40	40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 19,424		47

Miller Health Care Center

ID# 0040659

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
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	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Miller Health Care Center

# 0040659

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	1,156,840	0	0	0	0	0	0	0	0	0	1,156,840	21
22	Employee Benefits & Payroll Taxes	0	45,704	0	0	0	0	0	0	0	0	0	45,704	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	1,202,544	0	0	0	0	0	0	0	0	0	1,202,544	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	0	1,202,544	0	0	0	0	0	0	0	0	0	1,202,544	29



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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, IL	Hospital
				Riverside Senior Livin	Kankakee, IL	Senior living
				Oakside Corporation	Kankakee, IL	DME/HHA/Retail pl

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	4	\$ 59,182	Riverside Medical Center		\$ 59,182		1
2	V	10	79,258	Riverside Medical Center		79,258		2
3	V	10	26,811	Riverside Medical Center		26,811		3
4	V	10	2,330	Riverside Medical Center		2,330		4
5	V	10	6,679	Riverside Medical Center		6,679		5
6	V	10	3,221	Riverside Medical Center		3,221		6
7	V	10	1,895	Oakside Corporation		1,895		7
8	V	10	56,478	Riverside Medical Center		56,478		8
9	V	17	160,906	Riverside Medical Center		160,906		9
10	V	21	12,000	Riverside Medical Center		1,168,840	1,156,840	10
11	V	21	4,800	Riverside Medical Center		4,800		11
12	V	22	137,431	Riverside Medical Center		183,135	45,704	12
13	V	10a	276,464	Riverside Medical Center		276,464		13
14	Total		\$ 827,455			\$ 2,029,999	\$ * 1,202,544	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:      01/01/2004      Ending:      12/31/2004

## 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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	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: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Riverside Medical Center  
 Street Address 350 North Wall Street  
 City / State / Zip Code Kankakee, IL 60901  
 Phone Number ( 815) 935-7256  
 Fax Number ( 815) 935-8160

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

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	21	Administrative services	Cost	132,961,953	2	\$ 23,355,612	\$ 60,995,224	6,654,127	\$ 1,168,840	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 23,355,612	\$ 60,995,224		\$ 1,168,840	25

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
			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			
		<b>A. Directly Facility Related</b>																	
		<b>Long-Term</b>																	
1		Bond - 1994		X	Building construction		1994	\$ 5,152,000	\$			\$ 52,055	1						
2		Bond - 2000		X	Building addition		2000	640,366				21,914	2						
3		Bond - 2004		X	Partial refinancing of 2000 bonds		2004	757,371				17,055	3						
4													4						
5													5						
		<b>Working Capital</b>																	
6													6						
7													7						
8													8						
9		<b>TOTAL Facility Related</b>						\$ 6,549,737	\$			\$ 91,024	9						
		<b>B. Non-Facility Related*</b>																	
10													10						
11													11						
12													12						
13													13						
14		<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15		<b>TOTALS (line 9+line14)</b>						\$ 6,549,737	\$			\$ 91,024	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* 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: **01/01/2004** Ending: **12/31/2004****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2003 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.)			\$	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	3
4.	Real Estate Tax accrual used for 2004 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	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:		1999	_____	8	
		2000	_____	9	
		2001	_____	10	
		2002	_____	11	
		2003	_____	12	
<b>FOR OHF USE ONLY</b>					
13	FROM R. E. TAX STATEMENT FOR 2003		\$		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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Miller Health Care Center COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0040659

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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?        YES        NO

If YES, attach an explanation & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name &amp; ID Number Miller Health Care Center

# 0040659 Report Period Beginning:

01/01/2004 Ending:

12/31/2004

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,164 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1C. Does the Operating Entity?  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

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

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

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF		1991	\$ 886,000	1
2					2
3	TOTALS			\$ 886,000	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100	1995	1995	\$ 3,539,943	\$ 158,504	20	\$ 158,504	\$	\$ 1,547,643	4
5	10	1999	1999	656,641	42,114	16	42,114		243,710	5
6	10	2001	2001	147,085	14,962	10	14,962		52,368	6
7		2002	2002	835	84	10	84		209	7
8		2004	2004	93,286	2,053	8	2,053		2,053	8
<b>Improvement Type**</b>										
9	Land improvements			63,411	5,765	13	5,765		54,768	9
10	Building service equipment			1,295,587	64,472	19	64,472		612,482	10
11	Land improvements - landscaping			4,688	469	10	469		3,517	11
12	Land improvements - walkways			15,388	1,026	15	1,026		6,669	12
13	Building - carpeting			2,370		5			2,370	13
14	Land improvements - landscaping and pond deck			25,379	2,539	10	2,539		13,959	14
15	Building - carpeting			3,125	625	5	625		2,813	15
16	Building service equipment - exterior electrical lighting			1,100	61	19	61		275	16
17	Land improvements - landscaping			16,069	1,398	13	1,398		4,893	17
18	Building service equipment - HVAC			2,551	127	20	127		447	18
19	Land improvements - courtyard concrete			640	32	20	32		80	19
20	Building service equipment - HVAC/water heaters			9,547	1,042	10	1,042		2,605	20
21	Building service equipment - HVAC/water heaters			5,003	439	12	439		658	21
22	Land improvements - gazebo			510	3	20	3		3	22
23	Building service equipment - waterline/sprinkler system revision			8,208	66	18	66		66	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

\*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:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
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										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 5,891,366	\$ 295,781		\$ 295,781	\$	\$ 2,551,588		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:

01/01/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 688,026	\$ 50,332	\$ 50,332	\$		\$ 510,498	71
72	Current Year Purchases	116,812	3,867	3,867			3,867	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 804,838	\$ 54,199	\$ 54,199	\$		\$ 514,365	75

D. Vehicle Depreciation (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				\$	\$	\$	\$		\$	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)	\$ 7,582,204	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 349,980	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 349,980	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,065,953	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Not applicable  
 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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</u>	\$ _____

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
 (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			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

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

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

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	Nurse Aide Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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 aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A C3	3884	hrs	\$ 87,741		\$	3,884	\$ 87,741	1
2	Licensed Speech and Language Development Therapist	L10A C3	469	hrs	12,697			469	12,697	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	L10A C3	8480	hrs	170,084			8,480	170,084	4
5	Physician Care			visits						5
6	Dental Care			visits						6
7	Work Related Program			hrs						7
8	Habilitation			hrs						8
9	Pharmacy			# of prescripts						9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Exceptional Care Program									12
13	Other (specify): Respiratory therapy	L10A C3	1257		29,822			1,257	29,822	13
14	TOTAL				\$ 300,344		\$	\$ 14,090	\$ 300,344	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number Miller Health Care Center

# 0040659

Report Period Beginning: 01/01/2004

Ending:

12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$ 243,600	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance 234,538 )	1,072,516		3
4 Supply Inventory (priced at )	374		4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	134,318		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): Due from Medicare	(3,162)		9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,447,646	\$	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	126,085		13
14 Buildings, at Historical Cost	4,443,285		14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost	2,126,835		16
17 Accumulated Depreciation (book methods)	(3,065,953)		17
18 Deferred Charges	43,055		18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (spe Due from RPT	4,239,738		22
23 Other(specify): Trustee-held assets	92,812		23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 8,005,857	\$	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 9,453,503	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 90,152	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable	227,671		29
30 Accrued Salaries Payable	417,237		30
31 Accrued Taxes Payable (excluding real estate taxes)	66,966		31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 <u>Accrued expenses</u>	41,543		36
37			37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 843,569	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable	4,475,014		41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43 <u>Due to RPT</u>	140,968		43
44			44
45 <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,615,982	\$	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,459,551	\$	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,993,952	\$	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 9,453,503	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,871,298	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,871,298	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	122,654	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 122,654	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 3,993,952	24 *

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

Facility Name & ID Number Miller Health Care Center

# 0040659

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

**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.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,010,882	1
2	Discounts and Allowances for all Levels	(1,032,859)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 4,978,023</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,129,064	6
7	Oxygen	61,900	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,190,964</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	25,022	13
14	Non-Patient Meals	14,092	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	638,045	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,210	19
20	Radiology and X-Ray	7,741	20
21	Other Medical Services	26,789	21
22	Laundry	18,740	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 760,639</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions	3,784	24
25	Interest and Other Investment Income***	33,141	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 36,925</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Extraordinary loss</u>	(189,770)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ (189,770)</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,776,781</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	512,309	31
32	Health Care	4,286,335	32
33	General Administration	1,316,130	33
<b>B. Capital Expense</b>			
34	Ownership	473,473	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	65,880	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,654,127</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>122,654</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 122,654</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return?  N/A  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.

Facility Name & ID Number Miller Health Care Center

# 0040659

Report Period Beginning: 01/01/2004

Ending:

12/31/2004

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	1,893	2,219	\$ 78,324	\$ 35.30	1
2	Assistant Director of Nursing	1,841	2,106	48,502	23.03	2
3	Registered Nurses	9,805	23,095	548,172	23.74	3
4	Licensed Practical Nurses	13,161	34,753	581,387	16.73	4
5	Nurse Aides & Orderlies	37,487	84,048	832,609	9.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,841	2,013	28,222	14.02	9
10	Activity Assistants	5,561	6,097	58,558	9.60	10
11	Social Service Workers	1,866	2,067	33,572	16.24	11
12	Dietician	34	34	800	23.53	12
13	Food Service Supervisor	3,815	4,037	54,762	13.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,569	25,144	206,521	8.21	15
16	Dishwashers	2,259	2,302	15,870	6.89	16
17	Maintenance Workers	1,861	2,146	58,899	27.45	17
18	Housekeepers	12,598	13,629	114,492	8.40	18
19	Laundry					19
20	Administrator	1,907	2,157	171,106	79.33	20
21	Assistant Administrator					21
22	Other Administrative	3,613	4,317	100,048	23.18	22
23	Office Manager	1,504	1,696	27,876	16.44	23
24	Clerical	6,491	6,835	67,915	9.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,807	2,067	52,715	25.50	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Admissions Coord	1,847	2,067	33,190	16.06	33
34	TOTAL (lines 1 - 33)	133,760	222,829	\$ 3,113,540 *	\$ 13.97	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	\$	35
36	Medical Director		36
37	Medical Records Consultant		37
38	Nurse Consultant		38
39	Pharmacist Consultant	1,474	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)	\$ 1,474	49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Judy Amiano	Administrator	0	\$ 160,906	Workers' Compensation Insurance	\$ 32,625	IDPH License Fee	\$	
				Unemployment Compensation Insurance	24,611	Advertising: Employee Recruitment		
				FICA Taxes	231,966	Health Care Worker Background Check		
				Employee Health Insurance	608,820	(Indicate # of checks performed _____)		
				Employee Meals	0			
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension	86,329			
				Life insurance	14,291			
				Disability insurance	8,257			
				Dental Insurance	15,181			
				Accrued vacation	4,724	Less: Public Relations Expense	( )	
				Professional liability insurance	32,447	Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 160,906	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Subclass 9200	8,333
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
C. Professional Services								
Vendor/Payee	Type		Amount					
Enloe Drugs	Pharmacy consultation		\$ 1,474					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 1,474					

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Miller Health Care Center

# 0040659

Report Period Beginning: 01/01/2004 Ending: 12/31/2004

## 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. LSN \$6,242 and INHAA \$100
- (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? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,837 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 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. Not applicable
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,880  
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 of Public Aid, 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. \$ 14,092
- (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. \$ 0
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Yes
- 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? Not applicable
- 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.** \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Incomplete at cost report due date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.