

Facility Name & ID Number Miller Health Care Center# 0040659 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment					
		2 Medicaid Recipient		3 Private Pay	4 Other		5 Total
8	SNF		11,534	10,794	22,328	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD	3,300	13,953		17,253	11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	3,300	25,487	10,794	39,581	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.37%D. How many bed-hold days during this year were paid by the Department? 9 (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 mealsF. Does the facility maintain a daily midnight census? YesG. 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 02/13/1995J. 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 53 and days of care provided 10,794Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	312,059	150,859	19,017	481,935	(35)	481,900	(9,968)	471,932		1
2	Food Purchase		241,752		241,752		241,752		241,752		2
3	Housekeeping	113,696	34,385	63,435	211,516	(63,134)	148,382		148,382		3
4	Laundry					63,007	63,007	(15,984)	47,023		4
5	Heat and Other Utilities			149,041	149,041		149,041		149,041		5
6	Maintenance	64,013	917	60,851	125,781		125,781		125,781		6
7	Other (specify):*										7
8	TOTAL General Services	489,768	427,913	292,344	1,210,025	(162)	1,209,863	(25,952)	1,183,911		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	2,797,191	712,211	69,099	3,578,501	(442)	3,578,059	11,137	3,589,196		10
10a	Therapy		41	469,562	469,603		469,603	56,887	526,490		10a
11	Activities	107,556	4,401	8,091	120,048		120,048		120,048		11
12	Social Services	70,212		608	70,820	(608)	70,212		70,212		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,974,959	716,653	547,360	4,238,972	(1,050)	4,237,922	68,024	4,305,946		16
	C. General Administration										
17	Administrative	186,808			186,808		186,808	23,940	210,748		17
18	Directors Fees										18
19	Professional Services			1,094	1,094	(1,094)					19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	121,599	21,465	155,267	298,331	(9,087)	289,244	41,418	330,662		21
22	Employee Benefits & Payroll Taxes			926,755	926,755		926,755	91,964	1,018,719		22
23	Inservice Training & Education										23
24	Travel and Seminar					11,393	11,393		11,393		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			49,294	49,294		49,294		49,294		26
27	Other (specify):* Admitting		63		63		63		63		27
28	TOTAL General Administration	308,407	21,528	1,132,410	1,462,345	1,212	1,463,557	157,322	1,620,879		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,773,134	1,166,094	1,972,114	6,911,342		6,911,342	199,394	7,110,736		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:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			404,281	404,281		404,281		404,281			30
31	Amortization of Pre-Op. & Org.			3,724	3,724		3,724		3,724			31
32	Interest			167,441	167,441		167,441	(78,754)	88,687			32
33	Real Estate Taxes			145,756	145,756		145,756	86,664	232,420			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bond			24,424	24,424		24,424		24,424			36
37	TOTAL Ownership			745,626	745,626		745,626	7,910	753,536			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			1,568	1,568		1,568	(1,568)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,920	61,920		61,920		61,920			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			63,488	63,488		63,488	(1,568)	61,920			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,773,134	1,166,094	2,781,228	7,720,456		7,720,456	205,736	7,926,192			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,968)			4
5	Telephone, TV & Radio in Resident Rooms	(4,304)			5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(15,984)			8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(28,753)			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	(50,000)			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,114)			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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (146,123)		\$	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	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)	1,358,791		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,358,791		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,212,668		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	(1,568)	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	TOTAL (C): (sum of lines 38-46)			\$ (1,568)		47

Miller Health Care Center

ID# 0040659

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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)	
	A. General Services													
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	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
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	CNA 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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
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	1,266,827	0	0	0	0	0	0	0	0	0	1,266,827	21
22	Employee Benefits & Payroll Taxes	0	91,964	0	0	0	0	0	0	0	0	0	91,964	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	TOTAL General Administration	0	1,358,791	0	0	0	0	0	0	0	0	0	1,358,791	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	1,358,791	0	0	0	0	0	0	0	0	0	1,358,791	29

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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/Retail Pharma

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 Linen	\$ 62,765	Riverside Medical Center		\$ 62,765	\$	1
2	V	10 DON Salary	86,904	Riverside Medical Center		86,904		2
3	V	10 Lab Services	38,762	Riverside Medical Center		38,762		3
4	V	10 Ambulance Services	2,998	Riverside Medical Center		2,998		4
5	V	10 Radioloby Services	6,933	Riverside Medical Center		6,933		5
6	V	10 Infusion Services	12,617	Riverside Medical Center		12,617		6
7	V	10 M/S supplies/drugs (Oakside)	3,113	Oakside Corporation		3,113		7
8	V	10 M/S supplies/drugs (RMC)	25,879	Riverside Medical Center		25,879		8
9	V	17 Administrative Salary	186,808	Riverside Medical Center		186,808		9
10	V	21 Administrative Services	12,000	Riverside Medical Center		1,278,827		1,266,827
11	V	21 Employee Drug Testing	4,800	Riverside Medical Center		4,800		11
12	V	22 Benefits	162,417	Riverside Medical Center		254,381		91,964
13	V	10A Respiratory/Therapy Services	443,901	Riverside Medical Center		443,901		13
14	Total		\$ 1,049,897			\$ 2,408,688	\$ *	1,358,791

* 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: 01/01/2007 Ending: 12/31/2007

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: 01/01/2007

Ending: 2/31/2007

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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	154,823,773	2	\$ 25,645,231	\$ 74,894,973	7,720,454	\$ 1,278,827	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					\$ 25,645,231	\$ 74,894,973		\$ 1,278,827	25

Facility Name & ID Number Miller Health Care Center# 0040659

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	Bond - 1994		X	Building Construction		1994	\$ 5,152,000	\$			\$ 127,750	1
2	Bond - 2000		X	Building Addition		2000	640,366				3,359	2
3	Bond - 2004		X	Partial refinancing of 2000 bonds		2004	757,371				36,332	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 6,549,737	\$			\$ 167,441	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 6,549,737	\$			\$ 167,441	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.)

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.		
1.	Real Estate Tax accrual used on 2006 report.		\$ 128,663	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.)		\$ 136,725	2
3.	Under or (over) accrual (line 2 minus line 1).		\$ 8,062	3
4.	Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 137,694	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.)		\$ 86,664	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 232,420	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	2002	8		
	2003	9		
	2004	10		
	2005	137,694	11	
	2006	136,725	12	
			FOR BHF USE ONLY	
			13 FROM R. E. TAX STATEMENT FOR 2006 \$	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: 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 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,

2006 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 Patt Marlinghaus

TELEPHONE (815) 935-7256 x3544 FAX #: (815) 935-8160

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of total 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 2006.

(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. <u>16-09-31-100-021</u>	<u>1600 Butterfield Road, Kankakee, IL</u>	<u>\$ 136,724.96</u>	<u>\$ 136,724.96</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 136,724.96</u>	<u>\$ 136,724.96</u>

B. Real Estate Tax Cost Allocation:

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 X 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Miller Health Care Center

0040659 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	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:

01/01/2007 Ending: 12/31/2007

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 BHF 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	\$ 103,606	18.31351	\$ 103,606		\$ 1,897,389	4
5	10	1999	1999	656,641	38,760	9.28759	38,760		359,987	5
6	10	2001	2001	147,085	14,393	6.69777	14,393		96,401	6
7		2004	2004	94,121	16,012	3.51043	16,012		56,209	7
8		2005	2005	205,826	39,418	2.499949	39,418		98,543	8
Improvement Type**										
9	Land Improvements		1995	63,411	1,152	52.54427	1,152		60,531	9
10	Building service equipment		1995	1,295,587	63,582	12.63996	63,582		803,674	10
11	Land Improvements - landscaping		1997	4,688	234	20.03419	234		4,688	11
12	Land Improvements - walkways		1998	15,388	1,026	9.5	1,026		9,747	12
13	Building - Carpeting		1998	2,370					2,370	13
14	Land Improvements - landscaping and pond deck		1999	25,379	2,537	8.502956	2,537		21,572	14
15	Building - Carpeting		2000	3,125					3,125	15
16	Building service equipment - exterior electrical lighting		2000	1,100	61	7.508197	61		458	16
17	Land improvements - landscaping		2001	16,069	1,398	6.5	1,398		9,087	17
18	Building service equipment - HVAC		2001	2,551	128	6.484375	128		830	18
19	Land improvements - courtyard concrete		2002	640	32	5.5	32		176	19
20	Building service equipment - HVAC/water heaters		2002	9,547	882	6.316327	882		5,571	20
21	Building service equipment - HVAC/water heaters		2003	5,003	439	4.498861	439		1,975	21
22	Land improvements - gazebo		2004	510	25	3.56	25		89	22
23	Building service equipment - Waterline/sprinkler system revisior		2004	8,208	514	3.498054	514		1,798	23
24	Land improvements - asphalt walkway		2005	7,574	947	2.499472	947		2,367	24
25	Building service equipment - waterheater/generator doors/compressor/HV		2005	8,142	647	2.500773	647		1,618	25
26	Building - Cabinets/Doors/Wall coverings		2006	131,916	22,424	1.500045	22,424		33,637	26
27	Building service equipment - HVAC/electrical/plumbing		2006	22,864	1,489	1.499664	1,489		2,233	27
28	Building - Physical Therapy Renovation		2007	21,417	833	1	833		833	28
29	Building service equipment - Fire alarm upgrade		2007	6,448	282	1	282		282	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

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)		\$ 6,295,553	\$ 310,821		\$ 310,821	\$	\$ 3,475,190		70

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

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	\$ 959,118	\$ 61,900	\$ 61,900	\$		\$ 152,949	71
72	Current Year Purchases	129,554	31,560	31,560			605,544	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,088,672	\$ 93,460	\$ 93,460	\$		\$ 758,493	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	2	
	Reference	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)	\$ 8,270,225	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 404,281	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 404,281	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)	\$ 4,233,683	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: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	TOTAL				\$ _____			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

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	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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input 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>2. CLASSROOM PORTION:</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 CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (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.)

	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	5043	hrs	\$ 137,254		\$ 0	5,043	\$ 137,254	1
2	Licensed Speech and Language Development Therapist	L10A C3	881	hrs	29,396		0	881	29,396	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	L10A C3	11096	hrs	271,912		0	11,096	271,912	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 Therapist	L10A C3	1274		30,999		0	1,274	30,999	13
14	TOTAL				\$ 469,561		\$	18,294	\$ 469,561	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 576,888	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (167,346))	1,113,198		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	132,678		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Medicare	(2,000)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,820,764	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	4,903,310		14
15	Leasehold Improvements, at Historical Cost	133,659		15
16	Equipment, at Historical Cost	2,404,726		16
17	Accumulated Depreciation (book methods)	(4,233,683)		17
18	Deferred Charges	29,046		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Due from RPT)	6,288,087		22
23	Other(specify): Trustee held assets	90,496		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,615,641	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 11,436,405	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 136,954	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	228,011		29
30	Accrued Salaries Payable	527,685		30
31	Accrued Taxes Payable (excluding real estate taxes)	73,081		31
32	Accrued Real Estate Taxes(Sch.IX-B)	137,694		32
33	Accrued Interest Payable	10,971		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	41,714		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,156,110	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,801,168		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Party	256,351		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,057,519	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,213,629	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 6,222,776	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 11,436,405	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,166,688	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,166,688	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,056,088	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,056,088	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)	\$ 6,222,776	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

VII. 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,839,506	1
2	Discounts and Allowances for all Levels	(1,535,697)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,303,809	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,622,481	6
7	Oxygen	8,080	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,630,561	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	30,901	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	584,375	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	63,294	19
20	Radiology and X-Ray	51,480	20
21	Other Medical Services	18,670	21
22	Laundry	15,984	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 764,704	23
D. Non-Operating Revenue			
24	Contributions	50,000	24
25	Interest and Other Investment Income***	27,468	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 77,468	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,776,542	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	558,687	31
32	Health Care	5,133,826	32
33	General Administration	1,366,168	33
B. Capital Expense			
34	Ownership	599,853	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	61,920	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,720,454	40
41	Income before Income Taxes (line 30 minus line 40)**	1,056,088	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,056,088	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 01/01/2007

Ending:

12/31/2007

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	1,744	2,083	\$ 92,074	\$ 44.20	1
2	Assistant Director of Nursing	2,001	2,166	57,457	26.53	2
3	Registered Nurses	26,851	29,673	829,143	27.94	3
4	Licensed Practical Nurses	29,322	31,626	623,403	19.71	4
5	CNAs & Orderlies	80,782	88,580	978,135	11.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,906	2,026	33,155	16.36	9
10	Activity Assistants	4,252	4,611	48,049	10.42	10
11	Social Service Workers	3,511	4,001	68,572	17.14	11
12	Dietician					12
13	Food Service Supervisor	3,567	4,097	70,090	17.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,032	23,335	208,699	8.94	15
16	Dishwashers	3,780	3,795	27,723	7.31	16
17	Maintenance Workers	1,814	2,083	64,017	30.73	17
18	Housekeepers	11,495	12,402	110,824	8.94	18
19	Laundry					19
20	Administrator	1,806	2,006	234,030	116.67	20
21	Assistant Administrator					21
22	Other Administrative	3,778	4,191	113,635	27.11	22
23	Office Manager	1,522	1,653	32,224	19.49	23
24	Clerical	7,875	8,097	83,988	10.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,341	2,569	72,635	28.27	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Admissions Coord	2,378	2,433	25,281	10.39	33
34	TOTAL (lines 1 - 33)	211,757	231,427	\$ 3,773,134 *	\$ 16.30	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	1,094	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)	\$ 1,094	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	Certified Nurse Assistants/Aides		52
53	TOTAL (lines 50 - 52)	\$	53

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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. Life Services Network & INHAA \$5,580
- (3) Did the nursing home make political contributions or payments to a political 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? _____
- (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. \$ 25,426 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 61,920
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,968
- (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? _____
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? 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. \$ 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. Audit incomplete at date of filing
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.