



Facility Name & ID Number Miller Health Care Center# 0040659 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## 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 43,920

	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	<u>70</u>	Skilled (SNF)	<u>70</u>	<u>25,620</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,300</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,920</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>8,346</u>	<u>13,947</u>	<u>22,293</u>	8
9	SNF/PED					9
10	ICF	<u>2,732</u>	<u>14,385</u>		<u>17,117</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,732</u>	<u>22,731</u>	<u>13,947</u>	<u>39,410</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.73%

D. How many bed-hold days during this year were paid by the Department?

41 (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? Yes

G. Do pages 3 &amp; 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 53 and days of care provided 13,947Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\* Is your fiscal year identical to your tax year? YES  NO Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	
	<b>A. General Services</b>											
1	Dietary	317,744	169,011	22,294	509,049	(724)	508,325	(10,118)	498,207			1
2	Food Purchase		244,375		244,375		244,375		244,375			2
3	Housekeeping	121,370	44,125	55,303	220,798	(54,400)	166,398		166,398			3
4	Laundry					54,222	54,222	(13,983)	40,239			4
5	Heat and Other Utilities			159,135	159,135		159,135		159,135			5
6	Maintenance	66,347	1,219	64,311	131,877		131,877		131,877			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	<b>505,461</b>	<b>458,730</b>	<b>301,043</b>	<b>1,265,234</b>	<b>(902)</b>	<b>1,264,332</b>	<b>(24,101)</b>	<b>1,240,231</b>			8
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	3,258,747	771,323	62,144	4,092,214	(985)	4,091,229		4,091,229			10
10a	Therapy		1,400	565,372	566,772	(208)	566,564	90,278	656,842			10a
11	Activities	120,838	4,243	8,633	133,714	(347)	133,367		133,367			11
12	Social Services	66,435			66,435		66,435		66,435			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	<b>3,446,020</b>	<b>776,966</b>	<b>636,149</b>	<b>4,859,135</b>	<b>(1,540)</b>	<b>4,857,595</b>	<b>90,278</b>	<b>4,947,873</b>			16
	<b>C. General Administration</b>											
17	Administrative	196,763			196,763		196,763	32,995	229,758			17
18	Directors Fees											18
19	Professional Services			3,749	3,749	(3,749)						19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	128,078	26,126	241,403	395,607	(7,020)	388,587	(38,776)	349,811			21
22	Employee Benefits & Payroll Taxes			980,907	980,907		980,907		980,907			22
23	Inservice Training & Education											23
24	Travel and Seminar					13,211	13,211		13,211			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			62,415	62,415		62,415		62,415			26
27	Other (specify):* <b>Admitting</b>	15,935			15,935		15,935		15,935			27
28	<b>TOTAL General Administration</b>	<b>340,776</b>	<b>26,126</b>	<b>1,288,474</b>	<b>1,655,376</b>	<b>2,442</b>	<b>1,657,818</b>	<b>(5,781)</b>	<b>1,652,037</b>			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,292,257</b>	<b>1,261,822</b>	<b>2,225,666</b>	<b>7,779,745</b>		<b>7,779,745</b>	<b>60,396</b>	<b>7,840,141</b>			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: 01/01/2008 Ending: 12/31/2008

12/31/2008

## 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
	<b>D. Ownership</b>										
30	Depreciation			372,384	372,384	372,384		372,384			30
31	Amortization of Pre-Op. & Org.			3,486	3,486	3,486		3,486			31
32	Interest			105,168	105,168	105,168		(18,359)	86,809		32
33	Real Estate Taxes			(146,725)	(146,725)	(146,725)		34,829	(111,896)		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* <b>Bond</b>			23,690	23,690	23,690			23,690		36
37	<b>TOTAL Ownership</b>			358,003	358,003	358,003		16,470	374,473		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			315	315	315		(315)			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	<b>TOTAL Special Cost Centers</b>			62,235	62,235	62,235		(315)	61,920		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,292,257	1,261,822	2,645,904	8,199,983	8,199,983		76,551	8,276,534		45

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

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**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	(10,118)			4
5	Telephone, TV & Radio in Resident Rooms	(3,692)			5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(13,983)			8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(18,359)			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	(35,084)			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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (81,236)		\$	30

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)	1,942,505		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,942,505		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 1,861,269		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.

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops		X	(315)	40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ (315)	47

BHF USE ONLY					
48		49		50	51
					52

Miller Health Care Center

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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	<b>Total</b>	0	49





Facility Name & ID Number Miller Health Care Center

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Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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
				Senior Living Center	Kankakee, IL	Senior Living
				Oakside Corporation	Kankakee, IL	DME/HHA/Retail R

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	Linen	\$ 51,830			\$ 51,830	\$	1
2	V	Lab Services	34,108			34,108		2
3	V	Ambulance Services	1,015			1,015		3
4	V	Radiology Services	8,289			8,289		4
5	V	Infusion Services	3,828			3,828		5
6	V	M/S supplies and drugs (Oakside)	2,607			2,607		6
7	V	M/S supplies and drugs (RMC)	77,737			77,737		7
8	V	Administrator Salary	196,763			196,763		8
9	V	Administrative Services	12,000			1,831,233	1,819,233	9
10	V	Employee Drug Testing	4,800			4,800		10
11	V	Benefits	137,315			260,587	123,272	11
12	V	Respiratory Services	6,953			6,953		12
13	V	Therapy Services	531,405			531,405		13
14	Total		\$ 1,068,650			\$ 3,011,155	\$ *	1,942,505 14

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

Facility Name &amp; ID Number

Miller Health Care Center

#

0040659

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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

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Report Period Beginning: 01/01/2008

Ending: 2/31/2008

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Administrative Services	Cost	2	\$ 36,846,316	\$ 81,827,517	8,199,982	\$ 1,831,233	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				\$ 36,846,316	\$ 81,827,517		\$ 1,831,233	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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Bond - 1994		X	Building Construction		1994	\$ 5,152,000	\$		\$ 72,231	1									
2	Bond - 2000		X	Building Addition		2000	640,366			2,584	2									
3	Bond - 2004		X	Partial refinancing of 2000 bonds		2004	757,371			30,353	3									
4											4									
5											5									
<b>Working Capital</b>																				
6											6									
7											7									
8											8									
9	<b>TOTAL Facility Related</b>						\$ 6,549,737	\$		\$ 105,168	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	\$		\$ 105,168	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

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2007 report.		\$ <b>137,694</b>	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.)		\$ <b>(9,031)</b>	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>(146,725)</b>	3																																	
4. Real Estate Tax accrual used for 2008 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>		\$ <b>34,829</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.		\$ <b>(111,896)</b>	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2003</td><td>_____</td><td>8</td></tr> <tr><td>2004</td><td>_____</td><td>9</td></tr> <tr><td>2005</td><td><b>137,694</b></td><td>10</td></tr> <tr><td>2006</td><td><b>136,725</b></td><td>11</td></tr> <tr><td>2007</td><td>_____</td><td>12</td></tr> </table>	2003	_____	8	2004	_____	9	2005	<b>137,694</b>	10	2006	<b>136,725</b>	11	2007	_____	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2007</td><td>\$ _____</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$ _____</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$ _____</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$ _____</td><td>16</td></tr> </table>	<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2007	\$ _____	13	14	PLUS APPEAL COST FROM LINE 5	\$ _____	14	15	LESS REFUND FROM LINE 6	\$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____	16
2003	_____	8																																		
2004	_____	9																																		
2005	<b>137,694</b>	10																																		
2006	<b>136,725</b>	11																																		
2007	_____	12																																		
<b>FOR BHF USE ONLY</b>																																				
13	FROM R. E. TAX STATEMENT FOR 2007	\$ _____	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$ _____	14																																	
15	LESS REFUND FROM LINE 6	\$ _____	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____	16																																	
<b>Prior year real estate taxes filed under protest. No future liabilities due.</b>																																				
<b>Real Estate taxes paid during the year are not actual. This is due to audit adjustments made after 2007 report was filed.</b>																																				

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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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 Bureau of Health Finance at (217) 782-1630.

**2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

01/01/2008 Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 47,164 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

C. 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, CNA 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	<u>Skilled Nursing Facility</u>		<u>1991</u>	<u>\$ 886,000</u>	1
2					2
3	<b>TOTALS</b>			<b>\$ 886,000</b>	3

Facility Name &amp; ID Number Miller Health Care Center

# 0040659

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	\$ 97,019	20.39193	\$ 97,019		\$ 1,994,408	4
5	10		1999	1999	656,641	38,758	10.28807	38,758		398,745	5
6	10		2001	2001	147,085	14,391	7.6987	14,391		110,792	6
7			2004	2004	94,121	16,013	4.49991	16,013		72,222	7
8			2005	2005	205,826	39,416	3.50008	39,416		137,959	8
	<b>Improvement Type**</b>										
9		Land Improvements		1995	63,411	1,152	53.54427	1,152		61,683	9
10		Building service equipment		1995	1,295,587	63,583	13.63976	63,583		867,257	10
11		Land Improvements - landscaping		1997	4,688					4,688	11
12		Land Improvements - walkways		1998	15,388	1,026	10.5	1,026		10,773	12
13		Building - carpeting		1998	2,370					2,370	13
14		Land Improvements - landscaping and pond decks		1999	25,379	2,539	9.49626	2,539		24,111	14
15		Building - carpeting		2000	3,125					3,125	15
16		Building service equipment - exterior electrical lighting		2000	1,100	61	8.5082	61		519	16
17		Land Improvements - landscaping		2001	16,069	1,398	7.5	1,398		10,485	17
18		Building service equipment - HVAC		2001	2,551	127	7.53543	127		957	18
19		Land Improvements - courtyard concrete		2002	640	32	6.5	32		208	19
20		Building service equipment - HVAC/water heaters		2002	9,547	721	8.72677	721		6,292	20
21		Building service equipment - HVAC/water heaters		2003	5,003	439	5.49886	439		2,414	21
22		Land Improvements - gazebo		2004	510	26	4.42308	26		115	22
23		Building service equipment - waterline/sprinkler system revision		2004	8,208	513	4.50487	513		2,311	23
24		Land Improvements - asphalt walkway		2005	7,574	947	3.49947	947		3,314	24
25		Building service equipment - water heater/generator doors/compressor/HV		2005	8,142	647	3.50077	647		2,265	25
26		Building - cabinets/doors/wall coverings		2006	131,916	22,425	2.49998	22,425		56,062	26
27		Building service equipment - HVAC/electrical/plumbing		2006	22,864	1,489	2.49966	1,489		3,722	27
28		Building - Physical Therapy renovation		2007	21,417	1,665	1.5003	1,665		2,498	28
29		Building service equipment - fire alarm upgrade		2007	6,448	562	1.50178	562		844	29
30		Land Improvements - Pergola and landscaping		2008	15,903	758	1	758		758	30
31		Building - carpeting/wallcoverings/lighting		2008	56,241	4,059	1	4,059		4,059	31
32		Building service equipment - Sprinkler/electrical/HVAC/plumbing		2008	28,343	792	1	792		792	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:

01/01/2008

Ending:

12/31/2008

XI. OWNERSHIP COSTS (continued)

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

1	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)	\$ 6,396,040	\$ 310,558		\$ 310,558	\$	\$ 3,785,748	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: 01/01/2008 Ending: 12/31/2008

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	\$ 1,087,422	\$ 51,417	\$ 51,417	\$		\$ 768,345	71
72	Current Year Purchases	167,442	10,409	10,409			10,409	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,254,864	\$ 61,826	\$ 61,826	\$		\$ 778,754	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)	\$ 8,536,904	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 372,384	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 372,384	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)	\$ 4,564,502	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.

Facility Name & ID Number Miller Health Care Center

# 0040659

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	<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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<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 CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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	4918 hrs	\$ 146,701		\$		4,918	\$ 146,701	1
2	Licensed Speech and Language Development Therapist	L10A C3	786 hrs	26,711				786	26,711	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A C3	13825 hrs	357,993				13,825	357,993	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	Other (specify):									12
13	Other (specify): <u>Respiratory Therapist</u>	L10A C3	1320	33,556				1,320	33,556	13
14	TOTAL			\$ 564,961		\$	\$	20,849	\$ 564,961	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Miller Health Care Center# 0040659Report Period Beginning: 01/01/2008

Ending:

12/31/2008

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 717,200	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (182,973) )	1,380,567		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,276		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due from Medicare</u>	(2,000)		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,111,043	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	9,803,275		14
15	Leasehold Improvements, at Historical Cost	149,561		15
16	Equipment, at Historical Cost	2,642,657		16
17	Accumulated Depreciation (book methods)	(4,604,817)		17
18	Deferred Charges	21,146		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 <u>Due from RPT</u>	4,096,996		22
23	Other(specify): <u>Trustee Held Assets</u>	94,171		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 12,202,989	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 14,314,032	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,190,136	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	256,115		29
30	Accrued Salaries Payable	637,970		30
31	Accrued Taxes Payable (excluding real estate taxes)	94,817		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,159		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	2,384		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,185,581	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,640,726		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due to Related Party</u>	761,419		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 4,402,145	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,587,726	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 7,726,306	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 14,314,032	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 6,255,386	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 6,255,386	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,470,920	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)	\$ 1,470,920	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)	\$ 7,726,306	24 *

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

Facility Name &amp; ID Number Miller Health Care Center

# 0040659

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	\$ 8,541,371	1
2	Discounts and Allowances for all Levels	(1,343,046)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,198,325	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,787,889	6
7	Oxygen	7,168	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,795,057	8
<b>C. Other Operating Revenue</b>			
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	35,916	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	618,246	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,394	19
20	Radiology and X-Ray	60,426	20
21	Other Medical Services	20,685	21
22	Laundry	13,983	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 799,650	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>NEG INT INCOME FROM LN 25</b>	(122,129)	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (122,129)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,670,903	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	657,176	31
32	Health Care	5,778,936	32
33	General Administration	1,197,252	33
<b>B. Capital Expense</b>			
34	Ownership	504,699	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	61,920	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,199,983	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,470,920	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,470,920	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: 01/01/2008

Ending:

12/31/2008

**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	1,852	2,041	\$ 97,168	\$ 47.61	1
2	Assistant Director of Nursing	3,576	4,348	124,060	28.53	2
3	Registered Nurses	27,429	30,402	875,059	28.78	3
4	Licensed Practical Nurses	37,451	40,800	823,786	20.19	4
5	CNAs & Orderlies	86,452	94,270	1,070,926	11.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,838	2,029	33,450	16.49	9
10	Activity Assistants	4,473	4,901	52,069	10.62	10
11	Social Service Workers	2,788	3,594	64,780	18.02	11
12	Dietician					12
13	Food Service Supervisor	3,634	3,804	61,076	16.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,508	23,626	214,485	9.08	15
16	Dishwashers	4,408	4,408	34,574	7.84	16
17	Maintenance Workers	1,831	2,122	64,815	30.54	17
18	Housekeepers	11,468	12,996	119,007	9.16	18
19	Laundry					19
20	Administrator	1,841	2,041	266,851	130.75	20
21	Assistant Administrator					21
22	Other Administrative	3,747	4,128	111,175	26.93	22
23	Office Manager	1,535	1,720	33,635	19.56	23
24	Clerical	8,236	8,653	91,394	10.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,471	3,934	106,489	27.07	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Admission Coord	3,532	3,708	47,458	12.80	33
34	TOTAL (lines 1 - 33)	231,070	253,525	\$ 4,292,257 *	\$ 16.93	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		3,749		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)		\$ 3,749		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: 01/01/2008

Ending: 12/31/2008

**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	\$ 196,763	Workers' Compensation Insurance	\$ 39,201	IDPH License Fee	\$	
				Unemployment Compensation Insurance	(792)	Advertising: Employee Recruitment		
				FICA Taxes	315,222	Health Care Worker Background Check		
				Employee Health Insurance	478,462	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
				Pension	94,060			
				Life Insurance	18,594			
				Disability Insurance	11,763			
				Dental Insurance	14,147			
				Health and Fitness	10,250			
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)					\$ 196,763	TOTAL (agree to Sch. V, line 20, col. 8)		\$
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 980,907	
Description				Amount			G. Schedule of Travel and Seminar**	
							Description	
							Amount	
							Out-of-State Travel	
							\$	
							In-State Travel	
							Subclass 9200	
							13,211	
							Seminar Expense	
							Entertainment Expense	
							( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$			TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 3,749			\$ 13,211	

\* Attach copy of IMRF notifications

\*\*See instructions.



**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? 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 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? \_\_\_\_\_
- (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? 11 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 24,070 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 benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,118
- (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? 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.