

Facility Name & ID Number Miller Health Care Center

0040659 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	110	Skilled (SNF)	110	40,260	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	50	Intermediate/DD	50	18,300	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,560	7

B. Census-For the entire report period.

	1 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		11,114	18,611	29,725	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	3,394	13,200		16,594	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,394	24,314	18,611	46,319	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.10%

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

29 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

Vending machines and guest/employee meals

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 02/13/1995

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 110 and days of care provided 18,611

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number

Miller Health Care Center

0040659

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	485,414	358,493	32,929	876,836		876,836	(32,465)	844,371		1
2	Food Purchase		49,820		49,820		49,820		49,820		2
3	Housekeeping	189,021	53,304	109,300	351,625	(19,217)	332,408		332,408		3
4	Laundry					19,217	19,217	(17,223)	1,994		4
5	Heat and Other Utilities			193,337	193,337		193,337		193,337		5
6	Maintenance	26,442	3,612	121,322	151,376		151,376		151,376		6
7	Other (specify):*										7
8	TOTAL General Services	700,877	465,229	456,888	1,622,994		1,622,994	(49,688)	1,573,306		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	4,844,697	733,089	36,699	5,614,485		5,614,485		5,614,485		10
10a	Therapy		25,545	2,228,963	2,254,508	7,774	2,262,282		2,262,282		10a
11	Activities	222,683	5,497	7,586	235,766		235,766		235,766		11
12	Social Services	90,243		111	90,354		90,354		90,354		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,157,623	764,131	2,273,359	8,195,113	7,774	8,202,887		8,202,887		16
	C. General Administration										
17	Administrative	176,353			176,353		176,353		176,353		17
18	Directors Fees										18
19	Professional Services			7,774	7,774	(7,774)					19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	396,615	50,702	182,761	630,078		630,078	(1,509)	628,569		21
22	Employee Benefits & Payroll Taxes			1,587,414	1,587,414		1,587,414	98,804	1,686,218		22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			96,276	96,276		96,276		96,276		26
27	Other (specify):* Admitting	58,815		750	59,565		59,565		59,565		27
28	TOTAL General Administration	631,783	50,702	1,874,975	2,557,460	(7,774)	2,549,686	97,295	2,646,981		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,490,283	1,280,062	4,605,222	12,375,567		12,375,567	47,607	12,423,174		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: 01/01/2012 Ending: 12/31/2012

12/31/2012

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			611,984	611,984	611,984		611,984				30
31	Amortization of Pre-Op. & Org.			10,026	10,026	10,026		10,026				31
32	Interest			620,215	620,215	620,215		(59,552)	560,663			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bond			15,570	15,570	15,570			15,570			36
37	TOTAL Ownership			1,257,795	1,257,795	1,257,795		(59,552)	1,198,243			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			744	744	744		(744)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			257,672	257,672	257,672			257,672			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			258,416	258,416	258,416		(744)	257,672			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,490,283	1,280,062	6,121,433	13,891,778	13,891,778		(12,689)	13,879,089			45

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

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

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	(32,465)			4
5	Telephone, TV & Radio in Resident Rooms	(1,509)			5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(17,223)			8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(59,552)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (110,749)		\$	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)	2,892,272		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,892,272		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 2,781,523		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			(744)		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	TOTAL (C): (sum of lines 38-46)			\$ (744)		47

Miller Health Care Center

ID# 0040659

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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:

01/01/2012

Ending:

12/31/2012

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	2,892,272	0	0	0	0	0	0	0	0	0	2,892,272	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	2,892,272	0	0	0	0	0	0	0	0	0	2,892,272	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	2,892,272	0	0	0	0	0	0	0	0	0	2,892,272	29

STATE OF ILLINOIS

Facility Name & ID Number Miller Health Care Center# 0040659

Report Period Beginning:

01/01/2012 Ending:

Summary B

12/31/2012

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	2,892,272	0	0	0	0	0	0	0	0	0	2,892,272	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Riverside Health System	100			Riverside Medical Cen	Kankakee	Hospital
				Riverside Senior Livin	Kankakee	Senior Living
				Oakside Corporation	Kankakee	DME/Retail Rx

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	\$ 19,217	Riverside Medical Center		\$ 19,217	\$	1	
2	V	10 DON Salary	102,376	Riverside Medical Center		102,376		2	
3	V	10 Med Supplies and Medication	18,646	Oakside Corporation		18,646		3	
4	V	10 Purchased Services	250,104	Riverside Medical Center		250,104		4	
5	V	17 Administrator Salary	176,353	Riverside Medical Center		176,353		5	
6	V	21 Administrative Services	12,000	Riverside Medical Center		2,904,272	2,892,272	6	
7	V	21 Employee Drug Testing	4,800	Riverside Medical Center		4,800		7	
8	V	22 Benefits	86,841	Riverside Medical Center		86,841		8	
9	V							9	
10	V							10	
11	V							11	
12	V							12	
13	V							13	
14	Total		\$ 670,337			\$ 3,562,609	\$ *	2,892,272	14

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Phillip Kambic	BOD						1
2	Edgar Lambert	BOD						2
3	Bill Douglas	BOD						3
4	Bill Dyon	BOD						4
5	David Hegg, MD	BOD						5
6	Mardene Hinton	BOD						6
7	James Kasler	BOD						7
8	Emma Lou Lemon	BOD						8
9	Jane Meyer	BOD						9
10	Bruce Payne	BOD						10
11	Joy Rose	BOD						11
12	Keith Moss, MD	BOD						12
13	Linda Mitchell	BOD						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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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: 01/01/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Riverside Medical Center
 Street Address 350 N. Wall Street
 City / State / Zip Code Kankakee, IL 60901
 Phone Number (815) 933-1671
 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		\$ 39,446,946	\$ 87,237,675	13,891,778	\$ 2,904,272	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				\$ 39,446,946	\$ 87,237,675		\$ 2,904,272	25

Facility Name & ID Number

Miller Health Care Center

0040659

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Bond-1994		X	Building Construction		1994	\$ 5,152,000	\$			\$ 6,963	1					
2	Bond-2004		X	Partial Refinancing of 2000 bonds		2004	757,371				17,011	2					
3	Bond-2009		X	Partial Refinancing of 2004 bonds		2009	9,594,258				596,241	3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 15,503,629	\$			\$ 620,215	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 15,503,629	\$			\$ 620,215	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 2011 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2007 _____	8	FOR BHF USE ONLY			
	2008 _____	9				
	2009 _____	10			13 FROM R. E. TAX STATEMENT FOR 2011 \$	13
	2010 _____	11			14 PLUS APPEAL COST FROM LINE 5 \$	14
	2011 _____	12			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.

2011 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 2011 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 2011.

	(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.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>_____</u>	\$ <u>_____</u>

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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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:

01/01/2012 Ending:

12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 81,649 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? (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).

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	TOTALS			\$ 886,000	3

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning:

01/01/2012 Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$ 65,016	35.37881	\$ 65,016	\$	\$ 2,316,192	4
5	10	1999	1999	656,641	29,730	17.56418	29,730		522,183	5
6	10	2001	2001	147,085	62	21.31046	62		146,866	6
7	40	2009	2009	7,937,516	187,432	3.65101	187,432		677,921	7
8										8
	Improvement Type**									
9	Land Improvements	1995		63,411					63,411	9
10	Building Service Equipment	1995		1,295,587	43,384	24.92142	43,384		1,081,191	10
11	Land Improvements-Landscaping	1997		4,688					4,688	11
12	Land Improvements-Walkways	1998		15,388	1,025	14.5122	1,025		14,875	12
13	Building-Carpeting	1998		2,370					2,370	13
14	Land Improvements-Landscaping and pond deck	1999		25,379					25,379	14
15	Building-Carpeting	2000		3,125					3,125	15
16	Building Service Equipment-Exterior Lighting	2000		1,100	61	12.5082	61		763	16
17	Land Improvements-Landscaping	2001		16,069	418	34.94498	418		14,607	17
18	Building Service Equipment-HVAC	2001		2,551	127	11.55118	127		1,467	18
19	Land Improvements-Courtyard Concrete	2002		640	32	10.5	32		336	19
20	Building Service Equipment-HVAC/Water Heater	2002		9,547	433	20.5358	433		8,892	20
21	Building Service Equipment-HVAC/Water Heater	2003		5,003	439	9.49203	439		4,167	21
22	Land Improvements-Gazebo	2004		510	26	8.34615	26		217	22
23	Building Service Equip-waterline/sprinkler system revision	2004		8,208	513	8.50877	513		4,365	23
24	Building-Carpeting/wallcoverings/lighting	2004		94,121	2,770	32.69538	2,770		90,028	24
25	Building-Carpeting/wallcoverings/painting/ceiling tile	2005		205,826	1,821	9.6032	1,821		201,637	25
26	Land Improvement-Asphalt walkway	2005		7,574	947	7.4982	947		7,101	26
27	Building Service Equip-water heater/generator/doors/compressor/HVAC	2005		8,142	647	7.50386	647		4,855	27
28	Building-cabinets/doors/wall coverings	2006		131,916	2,294	50.3762	2,294		115,563	28
29	Building Service Equipment-HVAC/electrical/plumbing	2006		22,864	1,488	6.50202	1,488		9,675	29
30	Building-Physical Therapy renovation	2007		21,417	1,664	5.5024	1,664		9,156	30
31	Building Service Equipment-Fire Alarm Upgrade	2007		6,448	562	5.50178	562		3,092	31
32	Land Improvements-Pergola and landscaping	2008		15,903	1,517	4.49967	1,517		6,826	32
33	Building-Carpeting/wallcoverings/lighting	2008		56,241	8,123	4.49908	8,123		36,546	33
34	Building Service Equip-Sprinkler/electrical/HVAC/plumbing	2008		28,343	1,584	4.5	1,584		7,128	34
35	Building Service Equip-Lighting Fixtures	2009		3,718	372	3.5	372		1,302	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:

01/01/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	Building Service Equip-Fire Suppression System	2009	\$ 2,021	\$ 81	3.5	\$ 81	\$	\$ 283	37
38	Building Service Equip-Back-up Generator	2009	980	55	3.5	55		190	38
39	Building Service Equip-Hood Exhaust System	2009	2,011	134	3.5	134		469	39
40	Building Service Equip-HVAC Unit	2009	2,758	552	3.5	552		1,931	40
41	Building Service Equip-Electric Auto Doors	2009	8,873	887	3.5	887		3,105	41
42	Building Service Equip-Emergency Generator	2010	4,218	211	2.5	211		527	42
43	Building Service Equip-HVAC Units	2010	5,651	377	2.5	377		942	43
44	Building Service Equip-Waterheaters	2010	16,644	1,664	2.5	1,664		4,160	44
45	Land Improvements-Enclosure Gates	2011	2,551	850	1.5	850		1,275	45
46	Building-Student Room Wallcovering, Flooring, Lighting	2011	2,881	169	1.5	169		254	46
47	Building-Copier Power Supply	2011	1,004	56	1.5	56		84	47
48	Building-Dining Room Flooring	2011	1,540	154	1.5	154		231	48
49	Building-Exit Lights	2011	1,155	77	1.5	77		116	49
50	Building-Wallcovering, Flooring, Lighting in Corridors	2011	77,025	4,531	1.5	4,531		6,796	50
51	Building-Day Room Flooring	2011	5,993	599	1.5	599		899	51
52	Building-Media Room Replacement Doors	2011	1,947	130	1.5	130		195	52
53	Building Service Equip-HVAC Replacement	2011	2,921	195	1.5	195		292	53
54	Building Service Equip-Kitchen Drain Line Replacement	2011	969	48	1.5	48		72	54
55	Building Service Equip-Emergency Generator Rebuild	2011	2,764	138	1.5	138		207	55
56	Building Service Equip-Partial Roof Replacement	2011	1,019	102	1.5	102		153	56
57	Building Service Equip-HVAC Replacement	2011	2,350	157	1.5	157		235	57
58	Building-Electrical Outlets	2012	2,688	75	1	75		75	58
59	Building-Sprinkler Heads	2012	8,360	167	1	167		167	59
60	Building-Electronic Door Closers	2012	1,275	43	1	43		43	60
61	Building-Smoke Detectors	2012	1,412	71	1	71		71	61
62	Building Service Equip-Generator Emergency Stops	2012	6,905	288	1	288		288	62
63	Building Service Equip-Generator Emergency Stops	2012	2,074	86	1	86		86	63
64	Building Service Equip-Dishwasher Electrical	2012	4,987	139	1	139		139	64
65	Building Service Equip-Pole Lighting	2012	3,003	100	1	100		100	65
66	Building Service Equip-Water Valves	2012	3,642	91	1	91		91	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 14,518,895	\$ 364,714		\$ 364,714	\$	\$ 5,409,400	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,016,412	\$ 223,962	\$ 223,962	\$		\$ 1,753,705	71
72	Current Year Purchases	397,983	23,308	23,308			23,308	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 3,414,395	\$ 247,270	\$ 247,270	\$		\$ 1,777,013	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	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)	\$ 18,819,290	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 611,984	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 611,984	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)	\$ 7,186,413	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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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	2	3	
		Drop-outs	Completed	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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	L10A C3	12159	hrs	\$ 862,995		\$	\$	12,159	\$ 862,995	1
2	Licensed Speech and Language Development Therapist	L10A C3	5090	hrs	342,375				5,090	342,375	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L10A C3	15824	hrs	1,008,209				15,824	1,008,209	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	541		15,096				541	15,096	13
14	TOTAL				\$ 2,228,675		\$	\$	33,614	\$ 2,228,675	14

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

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning: 01/01/2012

Ending:

12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(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	\$ 3,564,564	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 337,888)	1,648,931		3
4	Supply Inventory (priced at Cost)	6,944		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	19,478		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,239,917	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	12,900,867		14
15	Leasehold Improvements, at Historical Cost	152,112		15
16	Equipment, at Historical Cost	4,616,361		16
17	Accumulated Depreciation (book methods)	(7,162,045)		17
18	Deferred Charges	148,728		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Due from RPT)	8,213,544		22
23	Other(specify): Trustee Held Assets	988,450		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 19,858,017	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 25,097,934	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 264,135	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	278,775		29
30	Accrued Salaries Payable	401,360		30
31	Accrued Taxes Payable (excluding real estate taxes)	144,995		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	76,235		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	250,573		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,416,073	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	11,838,753		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Party	730,749		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,569,502	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,985,575	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 11,112,359	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 25,097,934	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 10,319,798	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 10,319,798	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	792,561	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)	\$ 792,561	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)	\$ 11,112,359	24 *

* This must agree with page 17, line 47.

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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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,796,066	1
2	Discounts and Allowances for all Levels	(2,202,999)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,593,067	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	7,169,858	6
7	Oxygen	457	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 7,170,315	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	35,672	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	659,459	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	90,904	19
20	Radiology and X-Ray	50,719	20
21	Other Medical Services	1,905	21
22	Laundry	17,223	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 855,882	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	65,075	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 65,075	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)	\$ 14,684,339	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	593,582	31
32	Health Care	9,348,779	32
33	General Administration	2,433,950	33
B. Capital Expense			
34	Ownership	1,257,795	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	257,672	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,891,778	40
41	Income before Income Taxes (line 30 minus line 40)**	792,561	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 792,561	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 417,683	44
45	Private Pay - Net Inpatient Revenue	4,288,571	45
46	Medicare - Net Inpatient Revenue	1,886,813	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,593,067	49

* 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.

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0040659

Report Period Beginning:

01/01/2012

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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	1,840	2,111	\$ 103,353	\$ 48.96	1
2	Assistant Director of Nursing	1,841	2,087	84,512	40.49	2
3	Registered Nurses	57,439	63,877	2,025,503	31.71	3
4	Licensed Practical Nurses	36,694	41,064	869,417	21.17	4
5	CNAs & Orderlies	108,839	119,530	1,460,515	12.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,869	2,132	39,079	18.33	9
10	Activity Assistants	9,605	10,603	130,023	12.26	10
11	Social Service Workers	3,823	4,211	91,104	21.63	11
12	Dietician					12
13	Food Service Supervisor	1,893	2,124	37,563	17.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,385	38,213	400,579	10.48	15
16	Dishwashers	5,506	5,872	51,923	8.84	16
17	Maintenance Workers	1,829	2,111	73,201	34.68	17
18	Housekeepers	14,641	16,084	162,995	10.13	18
19	Laundry	1,324	1,447	13,444	9.29	19
20	Administrator	2,014	2,111	81,207	38.47	20
21	Assistant Administrator					21
22	Other Administrative	11,504	12,877	362,241	28.13	22
23	Office Manager	1,905	2,111	45,664	21.63	23
24	Clerical	14,175	15,210	187,122	12.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,588	4,958	145,162	29.28	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Admissions Coord</u>	6,695	7,128	125,676	17.63	33
34	TOTAL (lines 1 - 33)	323,409	355,861	\$ 6,490,283 *	\$ 18.24	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	7,774		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)	\$ 7,774		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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 \$5,435
- (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. \$ 17,660 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. \$ 257,672
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. \$ 32,465
- (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. \$ _____
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
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.