

Facility Name & ID Number Miller Healthcare Center

0040659 Report Period Beginning: 1/01/17 Ending: 12/31/17

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	110	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,400	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		8,063	20,057	28,120	8
9	SNF/PED					9
10	ICF	2,509	13,468		15,977	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,509	21,531	20,057	44,097	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.51%

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

0 (Do not include bed reserve days in Section B.)

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES NO

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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

YES NO

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 02/13/1995 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 20,057

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/01/17 Ending: 12/31/17

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	591,520	41,706	46,914	680,140		680,140	-	680,140		1
2	Food Purchase		374,685		374,685		374,685	(53,024)	321,661		2
3	Housekeeping	209,378	47,361	137,694	394,433		394,433	-	394,433		3
4	Laundry	-	-	-	-	-	-	-	-		4
5	Heat and Other Utilities			274,851	274,851		274,851	-	274,851		5
6	Maintenance	84,998	7,657	137,123	229,778		229,778	-	229,778		6
7	Other (specify):*	-	-	-	-		-	-	-		7
8	TOTAL General Services	885,896	471,409	596,582	1,953,887	-	1,953,887	(53,024)	1,900,863		8
	B. Health Care and Programs										
9	Medical Director	-	-	-	-		-	6,300	6,300		9
10	Nursing and Medical Records	5,559,003	1,200,424	168,473	6,927,900		6,927,900	(14,463)	6,913,437		10
10a	Therapy	-	-	-	-		-	-	-		10a
11	Activities	273,693	4,193	6,461	284,347		284,347	-	284,347		11
12	Social Services	114,434	-	-	114,434		114,434	-	114,434		12
13	CNA Training	-	-	-	-		-	-	-		13
14	Program Transportation	-	-	-	-		-	-	-		14
15	Other (specify):*	-	-	-	-		-	-	-		15
16	TOTAL Health Care and Programs	5,947,130	1,204,617	174,934	7,326,681	-	7,326,681	(8,163)	7,318,518		16
	C. General Administration										
17	Administrative	141,777	-	-	141,777		141,777	-	141,777		17
18	Directors Fees			-	-		-	-	-		18
19	Professional Services			-	-		-	-	-		19
20	Dues, Fees, Subscriptions & Promotions			19,420	19,420		19,420	5,136	24,556		20
21	Clerical & General Office Expenses	404,238	21,794	102,107	528,139		528,139	2,612,605	3,140,744		21
22	Employee Benefits & Payroll Taxes			1,962,512	1,962,512		1,962,512	(106,891)	1,855,621		22
23	Inservice Training & Education			-	-		-	-	-		23
24	Travel and Seminar			11,527	11,527		11,527	(738)	10,789		24
25	Other Admin. Staff Transportation		-	-	-		-	-	-		25
26	Insurance-Prop.Liab.Malpractice			69,892	69,892		69,892	-	69,892		26
27	Other (specify):* Mgmt. Co Benefits	-	-	-	-		-	117,794	117,794		27
28	TOTAL General Administration	546,015	21,794	2,165,458	2,733,267	-	2,733,267	2,627,906	5,361,173		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,379,041	1,697,820	2,936,974	12,013,835	-	12,013,835	2,566,719	14,580,554		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

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Report Period Beginning:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			573,836	573,836		573,836	21,691	595,527		30
31	Amortization of Pre-Op. & Org.			8,053	8,053		8,053	-	8,053		31
32	Interest			361,033	361,033		361,033	(13,214)	347,819		32
33	Real Estate Taxes			-	-		-	-	-		33
34	Rent-Facility & Grounds			-	-		-	-	-		34
35	Rent-Equipment & Vehicles			-	-		-	50,259	50,259		35
36	Other (specify):*			-	-		-	-	-		36
37	TOTAL Ownership			942,922	942,922	-	942,922	58,736	1,001,658		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation	-	-	-	-		-	-	-		38
39	Ancillary Service Centers	-	89,100	2,207,581	2,296,681		2,296,681	(42,096)	2,254,585		39
40	Barber and Beauty Shops	-	-	-	-		-	-	-		40
41	Coffee and Gift Shops	-	-	-	-		-	-	-		41
42	Provider Participation Fee			232,475	232,475		232,475	-	232,475		42
43	Other (specify):* Non-Allowable Cos	-	-	3,798	3,798		3,798	(3,798)	-		43
44	TOTAL Special Cost Centers	-	89,100	2,443,854	2,532,954	-	2,532,954	(45,894)	2,487,060		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,379,041	1,786,920	6,323,750	15,489,711	-	15,489,711	2,579,561	18,069,272		45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(53,024)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,691	30		9
10	Interest and Other Investment Income	(13,214)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(490)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(29,635)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (74,672)		\$	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)	2,654,233		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,654,233		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 2,579,561		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	

Miller Healthcare Center

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Cable	\$ (3,308)	43	1
2	Offset unrealized gain/loss	1,982	6	2
3	Non-Allowable Lobbying Fee	(2,185)	20	3
4	Offset miscellaneous income	(16,612)	21	4
5	Non-Allowable travel	(867)	24	5
6	Offset derivative valuation	(8,645)	21	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	(29,635)		49

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 Living	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	\$ 80,321	Riverside Medical Center		\$ 80,321		1
2	V	10 Med Supplies and Medication	177	Oakside Corporation		177		2
3	V	10 Purchased Services	248,800	Riverside Medical Center		248,800		3
4	V	17 Administrator salary	152,445	Riverside Medical Center		152,445		4
5	V	21 Administrative services	12,000	Riverside Medical Center		2,655,330	2,643,330	5
6	V	21 Employee drug testing	4,800	Riverside Medical Center		4,800		6
7	V	22 Benefits	106,891	Riverside Medical Center			(106,891)	7
8	V	27 Benefits		Riverside Medical Center		117,794	117,794	8
9	V	39 Therapy Services	14,416	Riverside Medical Center		14,416		9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 619,850			\$ 3,274,083	\$ * 2,654,233	14

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

Facility Name & ID Number

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VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board of Directors							1
2								2
3	Bruce Fitzpatrick							3
4	Maggie Frogge							4
5	Kathy Gagliano							5
6	David Hegg, M.D.	Chairman						6
7	Claudette Hemenover							7
8	Mardene Hinton							8
9	Linda Mitchell, Ed.D.	Secretary						9
10	Keith Moss, M.D.							10
11	Phillip Kambic	President						11
12	Bruce Payne	Vice Chairman						12
13	Joy Rose							13
14	Norman Strasma							14
15	Dave Tyson							15
16	Bill Douglas	Treasurer						16
17	Pamela Hull	Asst. Secretary						17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29		0						29
30		0						30

Facility Name & ID Number Miller Healthcare Center # 0040659 Report Period Beginning: 1/01/17 Ending: 12/31/17

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

1	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Please Page 6-Supplemental for listing of board of directors.			0.00				\$		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

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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

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

Name of Related Organization Riverside Medical Center
 Street Address 350 N. Wall Street
 City / State / Zip Code Kankakee, IL 60901
 Phone Number (815) 933-1671
 Fax Number ()

1	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	4	Linen	Cost	1	\$ 80,321	\$	1	\$ 80,321	1
2	10	Med Supplies and Medication	Cost	1	177		1	177	2
3	10	Purchased Services	Cost	1	248,800		1	248,800	3
4	17	Administrator salary	Cost	1	152,445		1	152,445	4
5	21	Administrative services	Cost	258,439,467	44,303,102	127,007,679	15,489,709	2,655,330	5
6	21	Employee drug testing	Cost	1	4,800		1	4,800	6
7	27	Benefits	Cost	1	117,794		1	117,794	7
8	39	Therapy Services	Cost	1	14,416		1	14,416	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				\$ 44,921,855	\$ 127,007,679		\$ 3,274,083	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			
A. Directly Facility Related																				
Long-Term																				
1	Bond-1994	X		Building Construction		1994	\$ 5,152,000	\$	2035	0.0600	\$ 3,979	1								
2	Bond-2009	X		Partial Refinancing of 2004 bonds		2009	9,594,258	2,860,353	2035	0.0600	181,912	2								
3	Bond-2015	X		Direct Replacement		2015	388,674	340,981	2029	Var	14,230	3								
4	Bond-2016	X		Refund 2006C and partial refunding 2009 bonds		2016	4,565,589	4,894,253	11/15/2045	0.0327	160,912	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 19,700,521	\$ 8,095,587			\$ 361,033	9								
B. Non-Facility Related*																				
10												10								
11												11								
12										Offset Interest Income	(13,214)	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (13,214)	14								
15	TOTALS (line 9+line14)						\$ 19,700,521	\$ 8,095,587			\$ 347,819	15								

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Miller Healthcare Center COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0040659

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1.	<u>Not-for-profit organization no real estate taxes are paid.</u>	\$ _____	\$ _____
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? NA 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.

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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).

Riverside Medical Center - 325 bed hospital

Butterfield Court - Assisted Living Facility - 96 beds

Westwood Oaks / Westwood Estates - Independent Living Facility - 90 beds

Total campus including the SNF is 13.26 acraa or 577,605.60 square feet.

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

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	Accumulated Depreciation
4	100	1995	1995	\$ 3,539,943	\$ 50,982	44	\$ 50,982	\$ 2,606,194
5	10	1999	1999	656,641	12,956	30	12,956	616,815
6	10	2001	2001	147,085		15		147,085
7	40	2009	2009	7,937,516	185,868	44	185,868	1,610,682
8					-		-	
Improvement Type**								
9	Land Improvements		1995	63,411				63,411
10	Building Service Equipment		1995	1,295,587	9,068	25	9,068	1,212,322
11	Land Improvements-Landscaping		1997	4,688				4,688
12	Land Improvements-Walkways		1998	15,388				15,388
13	Building-Carpeting		1998	2,370				2,370
14	Land Improvements-Landscaping and pond dec		1999	25,379				25,379
15	Building-Carpeting		2000	3,125				3,125
16	Building Service Equipment-Exterior Lighting		2000	1,100	61	18	61	1,069
17	Land Improvements-Landscaping		2001	16,069				16,069
18	Building Service Equipment-HVAC		2001	2,551	128		128	2,105
19	Land Improvements-Courtyard Concrete		2002	640	32		32	496
20	Building Service Equipment-HVAC/Water Heater		2002	9,547	73		73	9,547
21	Building Service Equipment-HVAC/Water Heater		2003	5,003	123		123	4,941
22	Land Improvements-Gazebo		2004	510	25		25	344
23	Building Service Equip-waterline/sprinkler system revision		2004	8,208	259		259	6,042
24	Building-Carpeting/wallcoverings/lighting		2004	94,121				94,121
25	Building-Carpeting/wallcoverings/painting/ceiling tile		2005	205,826				205,826
26	Land Improvements-Asphalt walkway		2005	7,574				7,574
27	Building Service Equip-water heater/generator/doors/compressor/HVAC		2005	8,142	335		335	7,309
28	Building-cabinets/doors/wall coverings		2006	131,916	1,665		1,665	126,089
29	Building Service Equipment-HVAC/electrical/plumbing		2006	22,864	1,111		1,111	16,548
30	Building-Physical Therapy renovation		2007	21,417	1,173		1,173	16,987
31	Building Service Equipment-Fire Alarm Upgrade		2007	6,448	327		327	5,669
32	Land Improvements-Pergola and landscaping		2008	15,903	1,517		1,517	14,412
33	Building-Carpeting/wallcoverings/lighting		2008	56,241	3,048		3,048	54,318
34	Building Service Equip-Sprinkler/electrical/HVAC/plumbing		2008	28,343	1,389		1,389	14,167
35	Building Service Equip-Lighting Fixtures		2009	3,718	372		372	3,161
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

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0040659

Report Period Beginning:

1/01/17

Ending:

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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	25	\$ 81		\$ 688	37
38	Building Service Equip-Back-up Generator	2009	980	54	18	54		462	38
39	Building Service Equip-Hood Exhaust System	2009	2,011	134	15	134		1,139	39
40	Building Service Equip-HVAC Unit	2009	2,758		5			2,758	40
41	Building Service Equip-Electric Auto Doors	2009	8,873	888	10	888		7,542	41
42	Building Service Equip-Emergency Generator	2010	4,218	211	20	211		1,582	42
43	Building Service Equip-HVAC Units	2010	5,651	377	15	377		2,827	43
44	Building Service Equip-Waterheaters	2010	16,644	1,665	10	1,665		12,483	44
45	Land Improvements-Enclosure Gates	2010	2,551					2,551	45
46	Building Student Room Wallcovering, Flooring, Lighting	2011	2,881	169	17	169		1,101	46
47	Building Copier Power Supply	2011	1,004	56	18	56		364	47
48	Building-Dinning Room Flooring	2011	1,540	154	10	154		1,001	48
49	Building-Exit Lights	2011	1,155	77	15	77		501	49
50	Building-Wallcovering, Flooring, Lighting in Corridors	2011	77,025	4,531	17	4,531		29,451	50
51	Building-Day Room Flooring	2011	5,993	600	10	600		3,895	51
52	Building-Media Room Replacement Doors	2011	1,947	130	15	130		845	52
53	Building Service Equip-HVAC Replacement	2011	2,921	195	15	195		1,267	53
54	Building Service Equip-Kitchen Drain Line Replacement	2011	969	48	20	48		314	54
55	Building Service Equip-Emergency Generator Rebuild	2011	2,764	138	20	138		897	55
56	Building Service Equip-Partial Roof Replacement	2011	1,019	102	10	102		663	56
57	Building Service Equip-HVAC Replacement	2011	2,350	157	15	157		1,020	57
58	Building-Electrical Outlets	2011	2,688	149	18	149		820	58
59	Building-Sprinkler Heads	2012	8,360	334	25	334		1,837	59
60	Building-Electronic Door Closers	2012	1,275	85	15	85		468	60
61	Building-Smoke Detectors	2012	1,412	141	10	141		776	61
62	Building Service Equip-Generator Emergency Stops	2012	6,905	575	12	575		3,164	62
63	Building Service Equip-Generator Emergency Stops	2012	2,074	173	12	173		951	63
64	Building Service Equip-Dishwasher Electrical	2012	4,987	277	18	277		1,524	64
65	Building Service Equip-Pole Lighting	2012	3,003	200	15	200		1,100	65
66	Building Service Equip-Water Valves	2012	3,642	182	20	182		1,001	66
67									67
68	Land Improvements - Asphalt work, sealing, stripping and crack f	2013	16,575	78	8	78		16,301	68
69	Building Service Equip - Carpet replacement in common area and	2013	12,886	2,259	18	2,259		10,166	69
70	TOTAL (lines 4 thru 69)		\$ 14,548,356	\$ 284,732		\$ 284,732	\$	\$ 7,025,712	70

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

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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	
1	Totals from Page 12A, Carried Forward		\$ 14,548,356	\$ 284,732		\$ 284,732	\$	\$ 7,025,712	1
2	Building Service Equip - Suites kitchen ceiling tile replacement	2013	5239	524	10	524		2,358	2
3	Building Service Equip - duct insulation in suites J, K halls and ki	2013	18390	920	20	920		4,138	3
4	Building Service Equip - Replacement of courtyard doors and nev	2013	3766	285	15	285		1,286	4
5	Building Service Equip - Installation of Conduit to patient room a	2013	4245	225	20	225		1,015	5
6	Building Service Equip - Replace side roof HVAC Unit	2013	14492	1,449	10	1,449		6,521	6
7	Building Service Equip - Replace power supply and celing fans in c	2013	2299	151	18	151		679	7
8	Building Service Equip - Replace water heaters and repaired wate	2013	20271	1,893	25	1,893		8,519	8
9	Building Service Equip - TV's for skilled and intermediate commo	2013	6185	1,237	5	1,237		5,567	9
10									10
11	Building Service Equip - Remodel of bathroom in F101 Frozen pip	2014	11369	669	17	669		2,341	11
12	Building Service Equip - circuit board replacement for emergency	2014	9641	803	12	803		2,811	12
13	Building Service Equip - Replacement controls and upgrade board	2014	5602	449	15	449		1,574	13
14	Building Service Equip - Smoke detection & annunciator fire alar	2014	85705	8,571	10	8,571		29,997	14
15	Building Service Equip - Remodel of 5 bathrooms and storage are	2014	30000	1,765	17	1,765		6,177	15
16	Building Service Equip - Electrical express locks of suites main ent	2014	6160	616	10	616		2,156	16
17	Building Service Equip - Replacement of electronics for suites nur	2014	4704	471	10	471		1,646	17
18									18
19	Building - Replacement of circuit boards in	2015	4653	310	15	310		775	19
20	rooftop HVAC unit								20
21	Buildings - Drywall repair in F102	2015	4350	218	20	218		544	21
22	Building - Replacement of rooftop HVAC	2015	24014	1,601	15	1,601		4,002	22
23	Buildings - Watermain repair throughout facility	2015	9572	479	20	479		1,197	23
24	Bldg Svc Eq - Bathroom plumbing, flooring, paint, etc throughout	2015	36277	2,134	17	2,134		5,335	24
25									25
26	Building Service Equip - Miller Landscape - Courtyard Center of	2016	7373	737	10	737		1,106	26
27	Building Service Equip - Concrete - Courtyard Center of Building	2016	8500	567	15	567		850	27
28	Building Service Equip - Nurse Call System - Throughout the Buil	2016	6301	630	10	630		945	28
29	Building Service Equip - Grease Trap Kitchen	2016	23770	2,377	10	2,377		3,566	29
30	Building Service Equip - Painting Rooms 102,3,4,5,6,8,9,10	2016	22780	4,556	5	4,556		6,834	30
31	Building Service Equip - Exterior Painting Old Side	2016	29133	5,827	5	5,827		8,740	31
32	Building Service Equip - Transfer Switch Mechanical Rm	2016	20086	4,017	5	4,017		6,026	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,973,233	\$ 328,213		\$ 328,213	\$	\$ 7,142,417	34

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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 14,973,233	\$ 328,213		\$ 328,213	\$	\$ 7,142,417	1
2	Building Service Equip - Fire Dampers - Throughout the Building	2016	36,690	3,669	10	3,669		5,504	2
3	Building Service Equip - Rubber Roof Replacement	2016	327,910	32,791	10	32,791		49,187	3
4	Building Service Equip - Replace 5 - 7.5 Ton RTU & Exhaust Fan	2016	24,222	1,615	15	1,615		2,422	4
5	Building Service Equip - New Cooling RTU Electrical Rm	2016	17,000	1,133	15	1,133		1,700	5
6	Building Service Equip - Sliding Door - North Entrance	2016	9,927	993	10	993		1,489	6
7									7
8	Building Service Equip - Courtyard Plant Installation	2017	19,500	975	10	975		975	8
9	Building Service Equip - Corridors E, D and H Refinishing	2017	556,854	16,378	17	16,378		16,378	9
10	-wall coverings, paint, flooring, hand rails, nurses								10
11	stations and lighting								11
12	Building Service Equip - 3 Roof Top Units	2017	36,000	900	20	900		900	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20	To Reconcile to Book Depreciation			(21,691)			21,691		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	TOTAL (lines 1 thru 33)		\$ 16,001,336	\$ 364,976		\$ 386,667	\$ 21,691	\$ 7,220,972	34

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

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1/01/17

Ending:

12/31/17

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,265,634	\$ 197,127	\$ 197,127	\$		\$ 1,323,480	71
72	Current Year Purchases	167,774	11,733	11,733		5-15	11,733	72
73	Fully Depreciated Assets	720,288					720,288	73
74								74
75	TOTALS	\$ 3,153,696	\$ 208,860	\$ 208,860	\$		\$ 2,055,501	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$ -	\$ -	\$		\$	76
77					-	-				77
78					-	-				78
79					-	-				79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 20,041,032	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 573,836	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 595,527	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,691	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,276,473	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

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Report Period Beginning: 1/01/17

Ending: 12/31/17

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 50,259 Description: Bed Rental: \$42,096. CPM Machine Rental: \$8,163

(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	<u>N/A</u>		\$	\$	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.

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 checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</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>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	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	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	L39 C3	hrs	\$	11,944	\$ 731,110	\$	11,944	\$ 731,110	1
2	Licensed Speech and Language Development Therapist	L39 C3	hrs		4,269	234,925		4,269	234,925	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39 C3	hrs		21,847	1,241,546		21,847	1,241,546	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Therapy</u>	L39 C2					47,004		47,004	12
13	Other (specify):									13
14	TOTAL			\$	38,060	\$ 2,207,581	\$ 47,004	38,060	\$ 2,254,585	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.

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12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/17

(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	\$ 993,554	\$ 993,554	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 327,619)	1,785,005	1,785,005	3
4	Supply Inventory (priced at)	14,818	14,818	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	43,425	43,425	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,836,802	\$ 2,836,802	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		886,000	13
14	Buildings, at Historical Cost	13,520,716	12,281,185	14
15	Leasehold Improvements, at Historical Cost	1,338,539	3,720,151	15
16	Equipment, at Historical Cost	3,163,620	3,153,696	16
17	Accumulated Depreciation (book methods)	(8,113,321)	(9,276,473)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	126,550	126,550	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(126,550)	(126,550)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe See SCH 17A	15,548,795	15,548,795	22
23	Other(specify): <u>Trustee held assets</u>	705,741	705,741	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 26,164,090	\$ 27,019,095	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 29,000,892	\$ 29,855,897	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 355,082	\$ 355,082	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	114,524	114,524	29
30	Accrued Salaries Payable	884,531	884,531	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,225	13,225	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	56,698	56,698	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See SCH 17A</u>	346,424	346,424	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,770,484	\$ 1,770,484	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	7,981,063	7,981,063	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Third Party</u>	5,488,630	5,488,630	43
44	<u>Change in FV of Derivative</u>	47,175	47,175	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 13,516,868	\$ 13,516,868	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 15,287,352	\$ 15,287,352	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,713,540	\$ 14,568,545	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 29,000,892	\$ 29,855,897	48

*(See instructions.)

Facility Name: Miller Healthcare Center
 IDPH License ID Number: 0040659
 Fiscal Year End: 12/31/17

Schedule 17A

XV. Balance Sheet

Line 22 Long-Term Assets Other (specify):

	Description	Operating	After Consolidation
6-1037-1135	Bond Issue Costs,2009 Bond Issue Costs	39,287	39,287
6-1037-1145	Bond Issue Costs,2015 Bond Issue Costs	2,019	2,019
6-1037-1150	Bond Issue Costs,2016 Bond Issue Costs	60,226	60,226
6-1050-0820	Due From Third Party,Due From SLC	15,447,263	15,447,263
Total - Line 23		15,548,795	15,548,795

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

	Description	Operating	After Consolidation
6-1215-1602	Salary & Deductions,Fed W/H & FICA	22,849	22,849
6-1215-1604	Salary & Deductions,Pension Pay - GW	96,816	96,816
6-1215-1608	Salary & Deductions,Life Dep Disab	49,971	49,971
6-1215-1614	Salary & Deductions,General Wellness	(29,836)	(29,836)
6-1215-1620	Salary & Deductions,Trust Mark	1,284	1,284
6-1215-1621	Salary & Deductions,Occidental Life	(16,063)	(16,063)
6-1215-1624	Salary & Deductions,Samaritan	8	8
6-1215-1625	Salary & Deductions,Lead With Your Heart	729	729
6-1215-1626	Salary & Deductions,Hosp Bill	131	131
6-1215-1627	Salary & Deductions,Day Care Pay	234	234
6-1215-1628	Salary & Deductions,Garn	30,686	30,686
6-1215-1630	Salary & Deductions,Gift Shop Pay	(338)	(338)
6-1215-1631	Salary & Deductions,Personal Deduct	1,843	1,843
6-1215-1632	Salary & Deductions,Nursing Excellence	1,700	1,700
6-1215-1633	Salary & Deductions,RN License Renewal	2,360	2,360
6-1215-1634	Salary & Deductions,Family Pharmacy	180	180
6-1215-1635	Salary & Deductions,RHE Uniform Ded	(71)	(71)
6-1215-1637	Salary & Deductions,Vendor Fair	199	199
6-1215-1638	Salary & Deductions,Noncash Cr Acct	(5,856)	(5,856)
6-1215-1639	Salary & Deductions,Health Savings Acct	34,765	34,765
6-1215-1641	Salary & Deductions,Employee Wellness	3,243	3,243
6-1220-1700	Accrued Expenses,Accd Exp	296,496	296,496
6-1220-1730	Accrued Expenses,Public Aid Tax	(144,906)	(144,906)
Total - Line 36		346,424	346,424

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,678,041	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,678,041	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	35,502	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 35,499	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,713,540	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Miller Healthcare Center

0040659

Report Period Beginning: 1/01/17

Ending: 12/31/17

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

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,450,306	1
2	Discounts and Allowances for all Levels	(6,643,565)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,806,741	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,276,353	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 10,276,353	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	37,512	13
14	Non-Patient Meals	53,024	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	910,054	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	354,342	19
20	Radiology and X-Ray		20
21	Other Medical Services	29,223	21
22	Laundry	15,220	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,399,375	23
D. Non-Operating Revenue			
24	Contributions	6,255	24
25	Interest and Other Investment Income***	13,214	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,469	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See SCH 19A</u>	23,275	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 23,275	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,525,213	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,953,887	31
32	Health Care	7,326,681	32
33	General Administration	2,733,267	33
B. Capital Expense			
34	Ownership	942,922	34
C. Ancillary Expense			
35	Special Cost Centers	2,300,479	35
36	Provider Participation Fee	232,475	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,489,711	40
41	Income before Income Taxes (line 30 minus line 40)**	35,502	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 35,502	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 362,529	44
45	Private Pay - Net Inpatient Revenue	4,489,916	45
46	Medicare - Net Inpatient Revenue	(1,045,704)	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,806,741	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

^ - Entity is a cash basis taxpayer

Facility Name: Miller Healthcare Center
IDPH License ID Number: 0040659
Fiscal Year End: 12/31/17

Schedule 19A

XVII. Income Statement

Line 28a Other Revenue (specify):

	Description	Amount
6-3000-3224	Admin,Misc Rev	16,612
6-3000-7805	Admin,Derivative Valuation	8,645
6-3000-7845	Admin,Trustee Unrealized G/L	(1,982)
	Total - Line 28	<u>23,275</u>

Facility Name & ID Number Miller Healthcare Center

0040659

Report Period Beginning:

1/01/17

Ending:

12/31/17

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	1,791	2,074	\$ 152,421	\$ 73.49	1
2	Assistant Director of Nursing	3,203	3,842	164,888	42.92	2
3	Registered Nurses	61,256	67,610	2,317,694	34.28	3
4	Licensed Practical Nurses	25,964	29,035	787,227	27.11	4
5	CNAs & Orderlies	107,492	118,543	1,681,623	14.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,883	2,074	48,409	23.34	9
10	Activity Assistants	10,690	12,105	225,284	18.61	10
11	Social Service Workers	3,954	4,547	114,434	25.17	11
12	Dietician	359	367	8,595	23.42	12
13	Food Service Supervisor	3,601	4,074	70,095	17.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,972	37,262	467,153	12.54	15
16	Dishwashers	4,135	4,395	45,677	10.39	16
17	Maintenance Workers	4,029	4,029	84,998	21.10	17
18	Housekeepers	20,710	20,710	209,378	10.11	18
19	Laundry					19
20	Administrator	1,779	1,948	141,777	72.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,075	18,277	404,238	22.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Admissions</u>	14,535	15,507	455,150	29.35	33
34	TOTAL (lines 1 - 33)	315,428	346,399	\$ 7,379,041 *	\$ 21.30	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$	1(3)	35
36	Medical Director	Monthly 6,300	9(7)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 13,278	10(3)	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)	\$ 19,578		49

C. CONTRACT NURSES

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

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. LeadingAge IL - \$13,654
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? 5-15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,740 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 232,475
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? No Indicate the amount. \$ 53,024
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 0
 - d. Have vehicle usage logs been maintained? Adequate records have been maintained
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
 - g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees