

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0040659</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Miller HealthCare Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1601 Butterfield Trail</u> <u>Kankakee</u> <u>60901</u>																									
NumberCityZip Code																									
County: <u>Kankakee</u>																									
Telephone Number: <u>(815) 936-6500</u> Fax # <u>(815) 936-6502</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Patricia K. Vilt</u></td></tr><tr><td>(Title) <u>Vice President of Finance</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Patricia K. Vilt</u>	(Title) <u>Vice President of Finance</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Patricia K. Vilt</u>																								
	(Title) <u>Vice President of Finance</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>02/13/1995</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Rich Schiltz</u>																									
Telephone Number: <u>(815) 935-7256 x3492</u>																									
Email Address: _____																									

Facility Name & ID Number Miller HealthCare Center

0040659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,040</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>50</u>	Intermediate/DD	<u>50</u>	<u>18,200</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>160</u>	TOTALS	<u>160</u>	<u>58,240</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>11,194</u>	<u>19,313</u>	<u>30,507</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>2,940</u>	<u>13,370</u>		<u>16,310</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,940</u>	<u>24,564</u>	<u>19,313</u>	<u>46,817</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.39%

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

14 (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

X

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

YES

☐

NO

X

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

X

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

YES

X

NO

☐

If YES, enter number

of beds certified

110

and days of care provided

19,313

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

X

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

X

NO

☐

Tax Year:

12/31/2011

Fiscal Year:

12/31/2011

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

Facility Name & ID Number Miller HealthCare Center # 0040659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011
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	468,567	343,956	35,107	847,630		847,630	(24,007)	823,623			1
2	Food Purchase		59,043		59,043		59,043		59,043			2
3	Housekeeping	284,112	63,906	91,269	439,287	(91,269)	348,018		348,018			3
4	Laundry					91,269	91,269	(14,555)	76,714			4
5	Heat and Other Utilities			212,596	212,596		212,596		212,596			5
6	Maintenance	14,692	5,399	114,715	134,806		134,806		134,806			6
7	Other (specify):*											7
8	TOTAL General Services	767,371	472,304	453,687	1,693,362		1,693,362	(38,562)	1,654,800			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,734,174	854,012	222,449	5,810,635	8,470	5,819,105	3,406,417	9,225,522			10
10a	Therapy	2,427	10,046	2,134,929	2,147,402		2,147,402		2,147,402			10a
11	Activities	207,595	5,494	14,857	227,946		227,946		227,946			11
12	Social Services	86,017			86,017		86,017		86,017			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,030,213	869,552	2,372,235	8,272,000	8,470	8,280,470	3,406,417	11,686,887			16
	C. General Administration											
17	Administrative	65,250			65,250		65,250		65,250			17
18	Directors Fees											18
19	Professional Services			8,470	8,470	(8,470)						19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	342,015	69,700	633,172	1,044,887		1,044,887	(419,809)	625,078			21
22	Employee Benefits & Payroll Taxes			1,598,244	1,598,244		1,598,244	81,027	1,679,271			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,571	74,571		74,571		74,571			26
27	Other (specify):* Admitting	72,000		975	72,975		72,975		72,975			27
28	TOTAL General Administration	479,265	69,700	2,315,432	2,864,397	(8,470)	2,855,927	(338,782)	2,517,145			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,276,849	1,411,556	5,141,354	12,829,759		12,829,759	3,029,073	15,858,832			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.

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			706,373	706,373		706,373		706,373			30
31	Amortization of Pre-Op. & Org.			10,699	10,699		10,699		10,699			31
32	Interest			622,154	622,154		622,154	(60,839)	561,315			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Bond			20,475	20,475		20,475		20,475			36
37	TOTAL Ownership			1,359,701	1,359,701		1,359,701	(60,839)	1,298,862			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			(275)	(275)		(275)	275				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,774	131,774		131,774		131,774			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			131,499	131,499		131,499	275	131,774			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,276,849	1,411,556	6,632,554	14,320,959		14,320,959	2,968,509	17,289,468			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(24,007)			4
5	Telephone, TV & Radio in Resident Rooms	(5,250)			5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(14,555)			8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(61,942)			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	1,103			20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(414,559)			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)	\$ (519,210)		\$	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 Amount	2 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)	3,406,417		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,406,417		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 2,887,207		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops			275		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)			\$ 275		47

Miller HealthCare Center

ID# 0040659

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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

Summary A

12/31/2011

[illegible]

Summary B

12/31/2011

[illegible]

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	\$ 98,525	Riverside Medical Center		\$ 98,525		1
2	V	10	DON Salary	93,374	Riverside Medical Center		93,374		2
3	V	10	Med Supplies and Medication	25,194	Oakside Corporation		25,194		3
4	V	10	Purchased Services	231,720	Riverside Medical Center		231,720		4
5	V	17	Administrator Salary	26,720	Riverside Medical Center		26,720		5
6	V	21	Administrative Services	12,000	Riverside Medical Center		3,418,417	3,406,417	6
7	V	21	Employee Drug Testing	4,800	Riverside Medical Center		4,800		7
8	V	22	Benefits	81,027	Riverside Medical Center		81,027		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 573,360			\$ 3,979,777	\$ * 3,406,417	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								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Miller HealthCare Center # 0040659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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 HealthCare Center # 0040659 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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	21	Administrative Services	Cost	186,318,856		\$ 44,474,366	\$ 87,298,643	14,320,958	\$ 3,418,417	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					\$ 44,474,366	\$ 87,298,643		\$ 3,418,417	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	\$			\$ 8,113	1	
2	Bond-2000		X	Building Addition		2000	640,366					2	
3	Bond-2004		X	Partial Refinancing of 2000 bonds		2004	757,371				17,800	3	
4	Bond-2009		X	Partial Refinancing of 2004 bonds		2009	9,594,258				596,241	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 16,143,995	\$			\$ 622,154	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 16,143,995	\$			\$ 622,154	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 2010 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 2011 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:		2006	136,725	8	
		2007		9	
		2008		10	
		2009		11	
		2010		12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Miller HealthCare Center</u>	COUNTY	<u>Kankakee</u>
---------------	---------------------------------	--------	-----------------

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 2010 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 2010.

(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		\$	\$

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?

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

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	Skilled Nursing Facility		1991	\$ 886,000	1
2					2
3	TOTALS			\$ 886,000	3

Facility Name & ID Number Miller HealthCare Center

0040659

Report Period Beginning:

01/01/2011

Ending:

12/31/2011

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	\$ 65,018	34.37776	\$ 65,018	\$	2,251,176	4
5	10		1999	1999	656,641	29,732	16.56306	29,732		492,453	5
6	10		2001	2001	147,085	7,228	20.31046	7,228		146,804	6
7	40		2009	2009	7,937,516	187,433	2.65101	187,433		490,489	7
8											8
	Improvement Type**										
9	Land Improvements			1995	63,411					63,411	9
10	Building Service Equipment			1995	1,295,587	43,384	23.92142	43,384		1,037,807	10
11	Land Improvements-Landscaping			1997	4,688					4,688	11
12	Land Improvements-Walkways			1998	15,388	1,026	13.49903	1,026		13,850	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	11.5082	61		702	16
17	Land Improvements-Landscaping			2001	16,069	908	15.62665	908		14,189	17
18	Building Service Equipment-HVAC			2001	2,551	128	10.46875	128		1,340	18
19	Land Improvements-Courtyard Concrete			2002	640	32	9.5	32		304	19
20	Building Service Equipment-HVAC/Water Heater			2002	9,547	723	11.69986	723		8,459	20
21	Building Service Equipment-HVAC/Water Heater			2003	5,003	437	8.53089	437		3,728	21
22	Land Improvements-Gazebo			2004	510	25	7.64	25		191	22
23	Building Service Equip-waterline/sprinkler system revision			2004	8,208	514	7.49416	514		3,852	23
24	Building-Carpeting/wallcoverings/lighting			2004	94,121	2,812	31.68377	2,812		87,258	24
25	Building-Carpeting/wallcoverings/painting/ceiling tile			2005	205,826	1,821	8.6032	1,821		199,816	25
26	Land Improvement-Asphalt walkway			2005	7,574	946	6.50529	946		6,154	26
27	Building Service Equip-water heater/generator/doors/compressor/HVAC			2005	8,142	648	6.49383	648		4,208	27
28	Building-cabinets/doors/wall coverings			2006	131,916	12,359	9.1649	12,359		113,269	28
29	Building Service Equipment-HVAC/electrical/plumbing			2006	22,864	1,488	5.50202	1,488		8,187	29
30	Building-Physical Therapy renovation			2007	21,417	1,665	4.4997	1,665		7,492	30
31	Building Service Equipment-Fire Alarm Upgrade			2007	6,448	562	4.50178	562		2,530	31
32	Land Improvements-Pergola and landscaping			2008	15,903	1,517	3.49967	1,517		5,309	32
33	Building-Carpeting/wallcoverings/lighting			2008	56,241	8,122	3.49951	8,122		28,423	33
34	Building Service Equip-Sprinkler/electrical/HVAC/plumbing			2008	28,343	1,584	3.5	1,584		5,544	34
35	Building Service Equip-Lighting Fixtures			2009	3,718	372	2.5	372		930	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 HealthCare Center

0040659

Report Period Beginning:

01/01/2011 Ending: 12/31/2011

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	2.5	\$ 81	\$	\$ 202	37
38	Building Service Equip-Back-up Generator	2009	980	54	2.5	54		135	38
39	Building Service Equip-Hood Exhaust System	2009	2,011	134	2.5	134		335	39
40	Building Service Equip-HVAC Unit	2009	2,758	551	2.5	551		1,379	40
41	Building Service Equip-Electric Auto Doors	2009	8,873	887	2.5	887		2,218	41
42	Building Service Equip-Emergency Generator	2010	4,218	211	1.5	211		316	42
43	Building Service Equip-HVAC Units	2010	5,651	377	1.5	377		565	43
44	Building Service Equip-Waterheaters	2010	16,644	1,664	1.5	1,664		2,496	44
45	Land Improvements-Enclosure Gates	2011	2,551	425	1	425		425	45
46	Building-Student Room Wallcovering, Flooring, Lighting	2011	2,881	85	1	85		85	46
47	Building-Copier Power Supply	2011	1,004	28	1	28		28	47
48	Building-Dining Room Flooring	2011	1,540	77	1	77		77	48
49	Building-Exit Lights	2011	1,155	39	1	39		39	49
50	Building-Wallcovering, Flooring, Lighting in Corridors	2011	77,025	2,265	1	2,265		2,265	50
51	Building-Day Room Flooring	2011	5,993	300	1	300		300	51
52	Building-Media Room Replacement Doors	2011	1,947	65	1	65		65	52
53	Building Service Equip-HVAC Replacement	2011	2,921	97	1	97		97	53
54	Building Service Equip-Kitchen Drain Line Replacement	2011	969	24	1	24		24	54
55	Building Service Equip-Emergency Generator Rebuild	2011	2,764	69	1	69		69	55
56	Building Service Equip-Partial Roof Replacement	2011	1,019	51	1	51		51	56
57	Building Service Equip-HVAC Replacement	2011	2,350	78	1	78		78	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 14,484,549	\$ 378,107		\$ 378,107	\$	\$ 5,044,686	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	\$2,618,260	\$295,520	\$295,520	\$		\$1,472,629	71
72	Current Year Purchases	398,152	32,746	32,746			32,746	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$3,016,412	\$328,266	\$328,266	\$		\$1,505,375	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)	\$18,386,961	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$706,373	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$706,373	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)	\$6,550,061	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

**

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

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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		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.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A C3	11644	hrs	\$ 824,577		\$	11,644	\$ 824,577	1
2	Licensed Speech and Language Development Therapist	L10A C3	4854	hrs	326,537			4,854	326,537	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	L10A C3	15064	hrs	961,730			15,064	961,730	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):									12
13	Other (specify): Respiratory Therapist	L10A C3	823		22,189			823	22,189	13
14	TOTAL				\$ 2,135,033		\$	\$	32,385 \$ 2,135,033	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,737,486	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 443,673)	2,140,070		3
4	Supply Inventory (priced at Cost)	7,245		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	19,096		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,903,897	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	12,898,679		14
15	Leasehold Improvements, at Historical Cost	152,112		15
16	Equipment, at Historical Cost	4,429,836		16
17	Accumulated Depreciation (book methods)	(6,620,956)		17
18	Deferred Charges	158,885		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Due from RPT	7,412,616		22
23	Other(specify): Trustee Held Assets	1,067,484		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 19,498,657	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 24,402,554	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 629,260	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	276,603		29
30	Accrued Salaries Payable	396,408		30
31	Accrued Taxes Payable (excluding real estate taxes)	203,760		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	76,484		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	176,318		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,758,833	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	12,167,545		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Party	234,691		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,402,236	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,161,069	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 10,241,485	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 24,402,554	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,058,460	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,058,460	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,183,025	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,183,025	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)	\$ 10,241,485	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,985,615	1
2	Discounts and Allowances for all Levels	(199,401)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,786,214	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,009,245	6
7	Oxygen	3,453	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,012,698	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	24,211	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	512,555	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	68,839	19
20	Radiology and X-Ray	51,417	20
21	Other Medical Services	11,130	21
22	Laundry	14,555	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 682,707	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22,363	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,363	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)	\$ 15,503,982	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	552,579	31
32	Health Care	9,470,851	32
33	General Administration	2,806,054	33
	B. Capital Expense		
34	Ownership	1,359,700	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	131,775	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,320,959	40
41	Income before Income Taxes (line 30 minus line 40)**	1,183,023	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,183,023	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

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

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

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	1,827	2,041	\$ 106,513	\$ 52.19	1
2	Assistant Director of Nursing	1,760	1,908	76,099	39.88	2
3	Registered Nurses	56,729	62,543	1,961,714	31.37	3
4	Licensed Practical Nurses	35,155	37,866	816,522	21.56	4
5	CNAs & Orderlies	105,770	116,365	1,452,155	12.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,848	2,103	38,044	18.09	9
10	Activity Assistants	8,759	9,468	117,601	12.42	10
11	Social Service Workers	3,785	4,070	85,393	20.98	11
12	Dietician					12
13	Food Service Supervisor	2,122	2,561	45,129	17.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,528	36,643	375,126	10.24	15
16	Dishwashers	5,546	5,785	50,946	8.81	16
17	Maintenance Workers	1,842	2,081	70,676	33.96	17
18	Housekeepers	14,801	16,284	161,367	9.91	18
19	Laundry					19
20	Administrator	1,916	2,150	72,831	33.87	20
21	Assistant Administrator					21
22	Other Administrative	11,200	12,588	345,084	27.41	22
23	Office Manager	1,910	2,091	42,689	20.42	23
24	Clerical	13,964	14,661	159,718	10.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	5,566	5,941	182,860	30.78	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Admissions Coord</u>	6,360	6,926	116,382	16.80	33
34	TOTAL (lines 1 - 33)	314,388	344,075	\$ 6,276,849 *	\$ 18.24	34

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		8,470		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)		\$ 8,470		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

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

** See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

Life Services Network \$4,875
- (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?

9 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

25,094

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.

\$

131,774

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.

\$

24,007
- (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 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.