

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0040659

Facility Name: Miller Health Care Center

Address: 1601 Butterfld Trail Kankakee 60901

County: Kankakee

Telephone Number: (815) 936-6500 Fax # (815) 936-6502

HFS ID Number:

Date of Initial License for Current Owners: 02/13/1995

Type of Ownership:

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501(c)3

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Amanda Springborn Telephone Number: (314) 925-3838

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 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.

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

(Signed)

(Date)

Paid Preparer

(Print Name and Title)

(Firm Name & Address) RSM US LLP 1450 American Way Suite 1400 Schaumburg, IL 60173-6084

(Telephone) (847) 517-7070 Fax # (847)517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number

Miller Health Care Center

0040659

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3	10	Intermediate (ICF)	10	3,650	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

2

3

4

5

6

7

8

9

	Level of Care	Patient Days by Level of Care and Primary Source of Payment									
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total		
				Medicaid Primary	Medicare Primary						
8	SNF	1,760	7,026			11,259	11,147	1,534	32,726	8	
9	SNF/PED									9	
10	ICF	321	2,014						2,335	10	
11	ICF/DD									11	
12	SC									12	
13	DD 16 OR LESS									13	
14	TOTALS	2,081	9,040			11,259	11,147	1,534	35,061	14	

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

60.04%

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 certified beds.

number of certified beds

110

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:

12/31/2025

Fiscal Year:

12/31/2025

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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	548,215	53,810	113,236	715,261		715,261		715,261			1
2	Food Purchase		411,483		411,483		411,483	(10,685)	400,798			2
3	Housekeeping	279,726	74,028	15,951	369,705		369,705		369,705			3
4	Laundry			73,856	73,856		73,856		73,856			4
5	Heat and Other Utilities			263,605	263,605		263,605		263,605			5
6	Maintenance	98,219	7,953	128,489	234,661		234,661	3,366	238,027			6
7	Other (specify):*											7
8	TOTAL General Services	926,160	547,274	595,137	2,068,571		2,068,571	(7,319)	2,061,252			8
	B. Health Care and Programs											
9	Medical Director							22,400	22,400			9
10	Nursing and Medical Records	4,563,741	848,284	1,254,081	6,666,106		6,666,106	77,823	6,743,929			10
10a	Therapy											10a
11	Activities	313,699	7,358	12,338	333,395		333,395		333,395			11
12	Social Services	247,487			247,487		247,487		247,487			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	5,124,927	855,642	1,266,419	7,246,988		7,246,988	100,223	7,347,211			16
	C. General Administration											
17	Administrative	238,653			238,653		238,653		238,653			17
18	Directors Fees											18
19	Professional Services							74,295	74,295			19
20	Dues, Fees, Subscriptions & Promotions			2,890	2,890		2,890	5,045	7,935			20
21	Clerical & General Office Expenses	173,771	8,939	300,669	483,379		483,379	2,201,414	2,684,793			21
22	Employee Benefits & Payroll Taxes			1,482,930	1,482,930		1,482,930		1,482,930			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,776	9,776		9,776		9,776			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			123,827	123,827		123,827		123,827			26
27	Other (specify):*											27
28	TOTAL General Administration	412,424	8,939	1,920,092	2,341,455		2,341,455	2,280,754	4,622,209			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,463,511	1,411,855	3,781,648	11,657,014		11,657,014	2,373,658	14,030,672			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 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			662,855	662,855		662,855	272,722	935,577			30
31	Amortization of Pre-Op. & Org.			3,428	3,428		3,428		3,428			31
32	Interest			127,510	127,510		127,510		127,510			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			866	866		866	29,712	30,578			35
36	Other (specify):*											36
37	TOTAL Ownership			794,659	794,659		794,659	302,434	1,097,093			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,117,999	1,117,999		1,117,999		1,117,999			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			452,168	452,168		452,168		452,168			42
43	Other (specify):* Non-Allowable Cos			1,837	1,837		1,837	(1,837)				43
44	TOTAL Special Cost Centers			1,572,004	1,572,004		1,572,004	(1,837)	1,570,167			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,463,511	1,411,855	6,148,311	14,023,677		14,023,677	2,674,255	16,697,932			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	(10,685)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,837)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	272,722	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(33,351)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 226,849		\$	30

BHF USE ONLY							
48		49		50		51	

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)	2,447,406		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 2,447,406		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 2,674,255		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.		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Offset Miscellaneous income	(36,342)	21	3
4	Adjust Fixed Assets under \$2,500	3,366	6	4
5	Chamber Dues	(375)	20	5
6				6
7				7
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(33,351)		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	N/A		Riverside Medical Cen	Kankakee	Hospital
				Riverside Senior Livin	Kankakee	Senior Living
				Oakside Corporation	Kankakee	DME/Retail Rx

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	4	Linen	\$ 73,856	Riverside Medical Center		\$ 73,856	\$	1
2	V	10	Purchased Services	281,226	Riverside Medical Center		281,226		2
3	V	21	Administrative services	12,000	Riverside Medical Center		2,459,406	2,447,406	3
4	V	21	Employee drug testing	4,800	Riverside Medical Center		4,800		4
5	V	39	Therapy Services	642	Riverside Medical Center		642		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 372,524			\$ 2,819,930	\$ * 2,447,406	14

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

STATE OF ILLINOIS			Ownership Listing-1				
Miller Health Care Center							
ID# 0040659							
Report Period Beginning: 01/01/2025							
Ending: 12/31/2025							
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)			Operator/Licensee		Building Co.	Management	
-Owners of companies must be listed instead of company names.			Ownership Percentage		Ownership Percentage	Co./Home Office Ownership Percentage	
-Names of trust beneficiaries must be listed.			Place of Residence				
First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	
1	Phillip	Kambie	President & CEO			1	
2	Maggie	Frogge	Chair			2	
3	David	Tyson	Vice-Chair			3	
4	Linda	Mitchel, PhD	Secretary			4	
5	Jeff	Bennet	Voting Member			5	
6	Ritu	Chandan, DO	Voting Member			6	
7	Yvonne	Christian-Williams	Voting Member			7	
8	Jeff	Hammes	Voting Member			8	
9	Jerald	Hoekstra	Voting Member			9	
10	Michael	O'Gorman	Voting Member			10	
11	Norman	Strasma	Voting Member			11	
12	Bruce	Payne	Voting Member			12	
13	Rebecca	Schiltz	VP of Post Acute Services / Staff			13	
14	Rich	Schiltz	Director of Finance / Staff			14	
15	Patt	Vilt	SVP & CFO / Staff			15	
16	Samantha	O'Connor	Assistant Secretary			16	
17	Mary	Schore	Voting Member			17	
18						18	
19						19	
20						20	
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72						72	
73						73	
74						74	
75						75	

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Please see ownership page 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

Facility Name & ID Number Miller Health Care Center # 0040659 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	4	Linen	Cost	1		\$ 73,856	\$	1	\$ 73,856	1
2	10	Purchased Services	Cost	1		281,226		1	281,226	2
3	21	Administrative services	Cost	358,547,787		62,880,416		14,023,676	2,459,406	3
4	21	Employee drug testing	Cost	1		4,800		1	4,800	4
5	39	Therapy Services	Cost	1		642		1	642	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 63,240,940	\$		\$ 2,819,930	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-2016	X		Refund 2006C and partial refun		2016	\$ 4,565,589	\$ 3,824,400	2045	0.0327	\$ 127,510	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,565,589	\$ 3,824,400			\$ 127,510	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,565,589	\$ 3,824,400			\$ 127,510	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.)

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 2024 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.)		2024	\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2025 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.		Alloc. Fr. Mgmt. Co.			
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
Assessed Value from Real Estate Tax Bill:		2024		8	
Real Estate Tax Bill for Calendar Year:		2020		9	
		2021		10	
		2022		11	
		2023		12	
		2024		13	
Not-for-profit organization: no real estate taxes are paid					

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	\$	14
15	PLUS APPEAL COST FROM LINE 5	\$	15
16	LESS REFUND FROM LINE 6	\$	16
17	AMOUNT TO USE FOR RATE CALCULATION	\$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Miller Health Care Center COUNTY Kankakee

FACILITY IDPH LICENSE NUMBER 0040659

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A)	(B)	(C)	(D) <u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u> <u>Nursing Home</u>
1.	<u>Not-for- profit organization no real estate taxes are paid</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u><u></u></u>	\$ <u><u></u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES N/A 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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 BrickFrame

Number of Stories 1

C. Does the Operating Entity?

X(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?

X(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X(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 acres or 577,605.60 square feet.

F. List the bed capacity for the building if it differs from the licensed total.

N.A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNO

No

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

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

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

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	\$ 50,986	44	\$ 50,986	\$	\$ 3,014,082	4
5	10		1999	1999	656,641		30			656,641	5
6	10		2001	2001	147,085		15			147,085	6
7	40		2009	2009	7,937,516	185,867	44	185,867		3,097,618	7
8											8
	Improvement Type**										
9	Land Improvements			1995	63,411					63,411	9
10	Building Service Equipment			1995	1,295,587	9,068	25	9,068		1,284,866	10
11	Land Improvements-Landscaping			1997	4,688					4,688	11
12	Land Improvements-Walkways			1998	15,388					15,388	12
13	Building-Carpeting			1998	2,370					2,370	13
14	Land Improvements-Landscaping and pond dec			1999	25,379					25,379	14
15	Building-Carpeting			2000	3,125					3,125	15
16	Building Service Equipment-Exterior Lighting			2000	1,100					1,100	16
17	Land Improvements-Landscaping			2001	16,069					16,069	17
18	Building Service Equipment-HVAC			2001	2,551					2,551	18
19	Land Improvements-Courtyard Concrete			2002	640	16			(16)	640	19
20	Building Service Equipment-HVAC/Water Heater			2002	9,547					9,547	20
21	Building Service Equipment-HVAC/Water Heater			2003	5,003					5,003	21
22	Land Improvements-Gazebo			2004	510	26			(26)	510	22
23	Building Service Equip-waterline/sprinkler system revision			2004	8,208	258		258		8,106	23
24	Building-Carpeting/wallcoverings/lighting			2004	94,121					94,121	24
25	Building-Carpeting/wallcoverings/painting/ceiling tile			2005	205,826					205,826	25
26	Land Improvements-Asphalt walkway			2005	7,574					7,574	26
27	Building Service Equip-water heater/generator/doors/compressor/HVAC			2005	8,142					8,142	27
28	Building-cabinets/doors/wall coverings			2006	131,916					131,916	28
29	Building Service Equipment-HVAC/electrical/plumbing			2006	22,864	1,110			(1,110)	22,864	29
30	Building-Physical Therapy renovation			2007	21,417	682			(682)	21,417	30
31	Building Service Equipment-Fire Alarm Upgrade			2007	6,448	90		90		6,389	31
32	Land Improvements-Pergola and landscaping			2008	15,903	832			(832)	15,903	32
33	Building-Carpeting/wallcoverings/lighting			2008	56,241	1,562			(1,562)	56,241	33
34	Building Service Equip-Sprinkler/electrical/HVAC/plumbing			2008	28,343	1,387		1,387		25,263	34
35	Building Service Equip-Lighting Fixtures			2009	3,718	371			(371)	3,718	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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		\$ 1,336	37
38	Building Service Equip-Back-up Generator	2009	980	55	18	55		902	38
39	Building Service Equip-Hood Exhaust System	2009	2,011	134	15		(134)	2,011	39
40	Building Service Equip-HVAC Unit	2009	2,758					2,758	40
41	Building Service Equip-Electric Auto Doors	2009	8,873	887	10		(887)	8,873	41
42	Building Service Equip-Emergency Generator	2010	4,218	211	20	211		3,270	42
43	Building Service Equip-HVAC Units	2010	5,651	377	15	185	(192)	5,651	43
44	Building Service Equip-Waterheaters	2010	16,644		10			16,644	44
45	Land Improvements-Enclosure Gates	2010	2,551					2,551	45
46	Building Student Room Wallcovering, Flooring, Lighting	2011	2,881	170	17	170		2,461	46
47	Building Copier Power Supply	2011	1,004	56	18	56		812	47
48	Building-Dinning Room Flooring	2011	1,540		10			1,540	48
49	Building-Exit Lights	2011	1,155	77	15	77		1,117	49
50	Building-Wallcovering, Flooring, Lighting in Corridors	2011	77,025	4,531	17	4,531		65,699	50
51	Building-Day Room Flooring	2011	5,993		10			5,993	51
52	Building-Media Room Replacement Doors	2011	1,947	130	15	130		1,885	52
53	Building Service Equip-HVAC Replacement	2011	2,921	195	15	195		2,827	53
54	Building Service Equip-Kitchen Drain Line Replacement	2011	969	49	20	49		706	54
55	Building Service Equip-Emergency Generator Rebuild	2011	2,764	138	20	138		2,001	55
56	Building Service Equip-Partial Roof Replacement	2011	1,019		10			1,019	56
57	Building Service Equip-HVAC Replacement	2011	2,350	156	15	156		2,268	57
58	Building-Electrical Outlets	2011	2,688	149	18	149		2,012	58
59	Building-Sprinkler Heads	2012	8,360	335	25	335		4,517	59
60	Building-Electronic Door Closers	2012	1,275	85	15	85		1,148	60
61	Building-Smoke Detectors	2012	1,412	72	10		(72)	1,412	61
62	Building Service Equip-Generator Emergency Stops	2012	6,905	576	12		(576)	6,905	62
63	Building Service Equip-Generator Emergency Stops	2012	2,074	173	12		(173)	2,074	63
64	Building Service Equip-Dishwasher Electrical	2012	4,987	277	18	277		3,740	64
65	Building Service Equip-Pole Lighting	2012	3,003	200	15	200		2,700	65
66	Building Service Equip-Water Valves	2012	3,642	182	20	182		2,457	66
67									67
68	Land Improvements - Asphalt work, sealing, stripping and crack f	2013	16,575		8			16,575	68
69	Building Service Equip - Carpet replacement in common area and	2013	12,886		18			12,886	69
70	TOTAL (lines 4 thru 69)		\$ 14,548,356	\$ 261,551		\$ 254,918	\$ (6,633)	\$ 9,146,303	70

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

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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	\$ 261,551		\$ 254,918	\$ (6,633)	\$ 9,146,303	1
2	<u>Building Service Equip - Suites kitchen ceiling tile replacement</u>	2013	5,239	524	10		(524)	5,239	2
3	<u>Building Service Equip - duct insulation in suites J, K halls and ki</u>	2013	18,390	919	20	919		11,490	3
4	<u>Building Service Equip - Replacement of courtyard doors and nev</u>	2013	3,766	286	15	251	(35)	3,364	4
5	<u>Building Service Equip - Installation of Conduit to patient room a</u>	2013	4,245	226	20	212	(14)	2,741	5
6	<u>Building Service Equip - Replace side roof HVAC Unit</u>	2013	14,492	1,449	10		(1,449)	14,492	6
7	<u>Building Service Equip - Replace power supply and celing fans in c</u>	2013	2,299	151	18	128	(23)	1,747	7
8	<u>Building Service Equip - Replace water heaters and repaired wate</u>	2013	20,271	1,893	25	811	(1,082)	17,170	8
9	<u>Building Service Equip - TV's for skilled and intermediate commo</u>	2013	6,185					6,185	9
10									10
11	<u>Building Service Equip - Remodel of bathroom in F101 Frozen pip</u>	2014	11,369	669	17	669		7,693	11
12	<u>Building Service Equip - circuit board replacement for emergency</u>	2014	9,641	804	12	804		9,243	12
13	<u>Building Service Equip - Replacement controls and upgrade board</u>	2014	5,602	449	15	373	(76)	4,713	13
14	<u>Building Service Equip - Smoke detection & annunciator fire alar</u>	2014	85,705	8,570	10		(8,570)	85,705	14
15	<u>Building Service Equip - Remodel of 5 bathrooms and storage are</u>	2014	30,000	1,765	17	1,765		20,297	15
16	<u>Building Service Equip - Electrical express locks of suites main ent</u>	2014	6,160	616	10		(616)	6,160	16
17	<u>Building Service Equip - Replacement of electronics for suites nur</u>	2014	4,704	470	10		(470)	4,704	17
18									18
19	<u>Building - Replacement of circuit boards in</u>	2015	4,653	310	15	310		3,255	19
20	<u>rooftop HVAC unit</u>								20
21	<u>Buildings - Drywall repair in F102</u>	2015	4,350	217	20	217		2,280	21
22	<u>Building - Replacement of rooftop HVAC</u>	2015	24,014	1,600	15	1,600		16,802	22
23	<u>Buildings - Watermain repair throughout facility</u>	2015	9,572	479	20	479		5,029	23
24	<u>Bldg Svc Eq - Bathroom plumbing, flooring, paint, etc throughout</u>	2015	36,277	2,134	17	2,134		22,407	24
25									25
26	<u>Building Service Equip - Miller Landscape - Courtyard Center of</u>	2016	7,373	737	10	737		7,002	26
27	<u>Building Service Equip - Concrete - Courtyard Center of Building</u>	2016	8,500	567	15	567		5,386	27
28	<u>Building Service Equip - Nurse Call System - Throughout the Buil</u>	2016	6,301	630	10	630		5,985	28
29	<u>Building Service Equip - Grease Trap Kitchen</u>	2016	23,770	2,377	10	2,377		22,582	29
30	<u>Building Service Equip - Painting Rooms 102,3,4,5,6,8,9,10</u>	2016	22,780		5			22,780	30
31	<u>Building Service Equip - Exterior Painting Old Side</u>	2016	29,133		5			29,133	31
32	<u>Building Service Equip - Transfer Switch Mechanical Rm</u>	2016	20,086		5			20,086	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 14,973,233	\$ 289,393		\$ 269,901	\$ (19,492)	\$ 9,509,973	34

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

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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 12B, Carried Forward		\$ 14,973,233	\$ 289,393		\$ 269,901	\$ (19,492)	\$ 9,509,973	1
2	Building Service Equip - Fire Dampers - Throughout the Building	2016	36,690	3,669	10	3,669		34,856	2
3	Building Service Equip - Rubber Roof Replacement	2016	327,910	32,791	10	32,791		311,515	3
4	Building Service Equip - Replace 5 - 7.5 Ton RTU & Exhaust Fan	2016	24,222	1,615	15	1,615		15,342	4
5	Building Service Equip - New Cooling RTU Electrical Rm	2016	17,000	1,133	15	1,133		10,764	5
6	Building Service Equip - Sliding Door - North Entrance	2016	9,927	993	10	993		9,433	6
7									7
8	Building Service Equip - Courtyard Plant Installation	2017	19,500	1,950	10	1,950		16,575	8
9	Building Service Equip - Corridors E, D and H Refinishing	2017	556,854	32,756	17	32,756		278,426	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	1,800	20	1,800		15,300	12
13									13
14	Building Services Equip - Landscape W Courtyard & Drip Irrigat	2018	23,500	2,350	10	2,350		17,625	14
15	Building Services Equip - New hot steam wells & countertops	2018	545,527	54,553	10	54,553		409,147	15
16	-including new electrical wiring. Replaced flooring & wall								16
17	-coverings - G Hall Dining Room								17
18	Building Services Equip - South entrance door replacement	2018	12,000	1,200	10	1,200		9,000	18
19	Landscaping Trees plants mulch stone	2019	6,591	330	10	659	329	4,285	19
20	Trane rooftop unit miller D hall RTU	2019	16,550	552	15	1,104	552	7,174	20
21	Miller ceiling tiles in assisted kitchen	2019	9,791	612	8	1,224	612	7,955	21
22	Kitchen RTU replacement	2019	60,911	2,030	15	4,061	2,031	26,394	22
23	IDPH replace pendants and fire tape	2019	7,226	213	17	425	212	2,763	23
24	Patient room upgrades painting-paint door frames	2019	181,423	5,336	17	10,672	5,336	69,367	24
25	bathrooms, patching, spot stain								25
26	Water heater replacement-boiler room	2019	8,455	423	10	846	423	5,496	26
27	R&M Replace electronic board on boiler	2019	4,446		20	222	222	1,445	27
28									28
29	Pt Room Renovations Phase 2-Install fire alarm cabling, relays &	2020	24,483	1,440	17	1,440		7,920	29
30	NW Svc Door & SW Main Entry & New doors at Employee Entr								30
31	Replacement of Rooftop Unit in D Hall	2020	17,000	1,133	15	1,133		6,232	31
32	New Compressor for RTU unit	2020	4,076	204	20	204		1,122	32
33	Water Heater Replacement-Suites Hallway	2020	14,400	720	20	720		3,960	33
34	TOTAL (lines 1 thru 33)		\$ 16,937,715	\$ 437,196		\$ 427,421	\$ (9,775)	\$ 10,782,070	34

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

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning:

01/01/2025 Ending: 12/31/2025

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 12C, Carried Forward		\$ 16,937,715	\$ 437,196		\$ 427,421	\$ (9,775)	\$ 10,782,070	1
2									2
3	MILLER VISITING SHED ACCESS CONTROL DEVICES	2021	3,532	706	5	706		3,179	3
4	AND AVIGILON CAMERAS								4
5	MILLER VISITING SHED CONSTRUCTION	2021	14,499	725	20	725		3,262	5
6									6
7	DITCH EROSION WORK - STONES	2022	17,700	1,770	10	1,770		5,605	7
8	DRAINAGE TILES, DOWN SPOUTS	2022	10,000	1,000	10	1,000		3,167	8
9	LANDSCAPING: RIVER ROCK, EDGERS	2022	11,850	1,185	10	1,185		3,753	9
10	EMPLOYEE ENTRANCE PAINTING	2022	4,886	977	5	977		3,909	10
11	EMPLOYEE ENTRANCE FLOORING	2022	6,566	438	15	438		1,714	11
12	PATIENT ROOM UPGRADES WALL RESTORE SINGLE RO	2022	21,000	4,200	5	4,200		15,750	12
13	PATIENT ROOM UPGRADES WALL RESTORE DOUBLE RO	2022	44,000	8,800	5	8,800		33,000	13
14	MAIN DINING ROOM FLOORING REPLACEMENT	2022	13,158	877	15	877		3,290	14
15	PATIENT ROOM UPGRADES WALL RESTORE SINGLE RO	2022	31,500	6,300	5	6,300		23,625	15
16	PATIENT ROOM UPGRADES WALL RESTORE DOUBLE RO	2022	33,000	6,600	5	6,600		24,750	16
17	PATIENT ROOM UPGRADES WALL RESTORE DOUBLE RO	2022	49,500	9,900	5	9,900		37,125	17
18	PATIENT ROOM UPGRADES WALL RESTORE DOUBLE RO	2022	66,000	13,200	5	13,200		49,500	18
19	PHYSICAL THERAPY DOOR REPLACEMENT	2022	14,000	933	15	933		3,033	19
20	PATIENT ROOM UPGRADES: CONTRACT \$136,935	2022	136,935	9,129	15	9,129		28,909	20
21									21
22	DITCH EROSION REPAIR - PHASE 2	2023	10,665	1,067	10	1,067	(1)	3,200	22
23	RENOVATE PT GYM WALLS	2023	18,513	604	30	617	13	1,838	23
24	AND CABINETS ON PT GYM WALL: 30X30X16, MAPLE								24
25									25
26	DITCH EROSION REPAIR - PHASE 2	2024	7,055	706	10	706		1,059	26
27	DITCH EROSION REPAIR - PHASE 3	2024	18,000	1,800	10	1,800		2,700	27
28	IRRIGATION SYSTEM INSTALL	2024	20,065	1,338	15	1,338		2,007	28
29	AIRMAX SHALLOW WATER SERIES AERATION SYSTEM	2024	2,400	160	15	160		240	29
30	J HALL ROOM RENOVATIONS: PATCH AND PAINT								30
31	CEILING, WALLS, TRIM	2024	90,917	18,183	5	18,183		27,275	31
32	DIALYSIS BOXES WITH REQUIRED PLUMBING WORK	2024	36,124	4,516	8	4,516		6,773	32
33	PAINT AND WALL WORK	2024	1,606	321	5	321		482	33
34	TOTAL (lines 1 thru 33)		\$ 17,621,186	\$ 532,631		\$ 522,868	\$ (9,763)	\$ 11,071,213	34

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$3,735,681	\$368,001	\$379,742	\$11,741	5-25	\$3,632,512	71
72	Current Year Purchases	368,561	11,144	11,144		5-25	11,144	72
73	Fully Depreciated Assets	869,217					869,217	73
74								74
75	TOTALS	\$4,973,459	\$379,145	\$390,886	\$11,741		\$4,512,873	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	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$24,048,949	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$662,855	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$935,577	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$272,722	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$15,611,194	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.

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

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: \$ 30,578
- Description:
- See Sch 14A

(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	N/A		\$	\$	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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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.

Facility Name:Miller Healthcare Center

IDPH License ID Number:0040659

Fiscal Year End:12/31/2025

Schedule 14A

XIV. Rental Costs

Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Bed Rental	-
CPM Machine Rental	866
Oxygen Rental	7,738
Wound Pump	21,975
Total - Line 16	30,578

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

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.

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	L39 C3	hrs	\$	5,209	\$ 410,237	\$	5,209	\$ 410,237	1
2	Licensed Speech and Language Development Therapist	L39 C3	hrs		693	49,027		693	49,027	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39 C3	hrs		9,000	658,093		9,000	658,093	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	L39 C3			17	642		17	642	12
13	Other (specify): <u> </u>									13
14	TOTAL			\$	14,919	\$ 1,117,999	\$	14,919	\$ 1,117,999	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.				
This report must be completed even if financial statements are attached.				
		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,894,722	\$ 3,894,722	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 365,544)	2,062,337	2,062,337	3
4	Supply Inventory (priced at)	12,426	12,426	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	29,792	29,792	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,999,277	\$ 5,999,277	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	15,332,786	12,281,185	14
15	Leasehold Improvements, at Historical Cost	1,442,780	5,908,305	15
16	Equipment, at Historical Cost	4,655,614	4,973,459	16
17	Accumulated Depreciation (book methods)	(12,957,594)	(15,611,194)	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 (sp) See Sch 17A	22,557,564	22,557,564	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 31,031,150	\$ 30,995,319	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 37,030,427	\$ 36,994,596	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 207,439	\$ 207,439	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	140,047	140,047	29
30	Accrued Salaries Payable	1,009,932	1,009,932	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	140,616	140,616	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Sch 17A	953,998	953,998	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,452,032	\$ 2,452,032	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,684,353	3,684,353	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Third Party	21,799,394	21,799,394	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 25,483,747	\$ 25,483,747	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 27,935,779	\$ 27,935,779	46
47	TOTAL EQUITY(page 18, line 24)	\$ 9,094,648	\$ 9,058,817	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 37,030,427	\$ 36,994,596	48

*(See instructions.)

Facility Name:Miller Health Care Center

IDPH License ID Number:0040659

Fiscal Year End:12/31/2025

Schedule 17A

XV. Balance Sheet

Line 22 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
BOND ISSUE COSTS 2016 BOND ISSUE COSTS	29,973	29,973
CONST IN PROCESS CURR CONST CAP INT	-	-
DUE FROM THIRD PARTY DUE FROM SLC	22,526,149	22,526,149
DUE FROM THIRD PARTY DUE FROM MEDICARE	-	-
SALARY & DEDUCTIONS UNITED WAY PAY	1,442	1,442
Total - Line 22	22,557,564	22,557,564
	-	-

XV. Balance Sheet

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
SALARY & DEDUCTIONS FED W/H & FICA	94,448	94,448
SALARY & DEDUCTIONS IL W/H PAY	(17,792)	(17,792)
SALARY & DEDUCTIONS PENSION PAY - GW	(257,572)	(257,572)
SALARY & DEDUCTIONS LIFE DEP DISAB	171,576	171,576
SALARY & DEDUCTIONS TDA PAY-MOA	(29,776)	(29,776)
SALARY & DEDUCTIONS LEGAL PLAN	191	191
SALARY & DEDUCTIONS TRUST MARK	1,240	1,240
SALARY & DEDUCTIONS OCCIDENTAL LIFE	17,371	17,371
SALARY & DEDUCTIONS LEAD WITH YOUR HEART	4,174	4,174
SALARY & DEDUCTIONS DAY CARE PAY	279	279
SALARY & DEDUCTIONS GARN	27,131	27,131
SALARY & DEDUCTIONS PERSONAL DEDUCT	537	537
SALARY & DEDUCTIONS RN LICENSE RENEWAL	80	80
SALARY & DEDUCTIONS NONCASH CR ACCT	(42,556)	(42,556)
SALARY & DEDUCTIONS HEALTH CARE PAY	812	812
SALARY & DEDUCTIONS EMPLOYEE WELLNESS	25	25
ACCRUED EXPENSES ACCD EXP-PMM	345,666	345,666
ACCRUED EXPENSES PUBLIC AID TAX	124,717	124,717
ACCRUED EXPENSES INCOME GUARANTEE	362,897	362,897
ACCRUED EXPENSES WORK COMP PAY	150,550	150,550
DUE TO THIRD PARTY DUE TO MED	-	-
Total - Line 36	953,998	953,998
	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,747,438	1
2	Restatements (describe):		2
3	Prior Period Adjustment	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,747,440	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(652,792)	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)	\$ (652,792)	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)	\$ 9,094,648	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Miller Health Care Center

0040659

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,929,400	1
2	Discounts and Allowances for all Levels	(3,374,047)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,555,353	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,020,606	6
7	Oxygen	82,226	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,102,832	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	12,361	13
14	Non-Patient Meals	10,685	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	550,219	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,483	19
20	Radiology and X-Ray	32,283	20
21	Other Medical Services	24,775	21
22	Laundry	4,552	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 676,358	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See SCH 19A</u>	36,342	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 36,342	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,370,885	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,068,571	31
32	Health Care	7,246,988	32
33	General Administration	2,341,455	33
	B. Capital Expense		
34	Ownership	794,659	34
	C. Ancillary Expense		
35	Special Cost Centers	1,119,836	35
36	Provider Participation Fee	452,168	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,023,677	40
41	Income before Income Taxes (line 30 minus line 40)**	(652,792)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (652,792)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 507,792.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	2,205,881.00	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	2,747,346.00	48
49	Medicare Part A	2,720,017.00	49
50	Other-(specify)	374,317.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,555,353	56

Facility Name:Miller Health Care Center

IDPH License ID Number:0040659

Fiscal Year End:12/31/2025

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
MILLER ADMIN MISC REV	36,342
Total - Line 28	36,342
	-

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	1,370	1,617	\$ 96,456	\$ 59.65	1
2	Assistant Director of Nursing	1,880	2,138	111,226	52.02	2
3	Registered Nurses	21,414	23,772	1,120,379	47.13	3
4	Licensed Practical Nurses	20,473	22,161	848,835	38.30	4
5	CNAs & Orderlies	76,210	82,243	2,386,845	29.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,850	2,080	66,516	31.98	9
10	Activity Assistants	10,929	12,051	247,183	20.51	10
11	Social Service Workers	6,528	7,966	247,487	31.07	11
12	Dietician					12
13	Food Service Supervisor	2,127	2,280	52,958	23.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,769	27,930	495,257	17.73	15
16	Dishwashers					16
17	Maintenance Workers	4,655	4,655	98,219	21.10	17
18	Housekeepers	15,480	15,480	279,726	18.07	18
19	Laundry					19
20	Administrator	2,787	3,049	238,653	78.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,384	6,747	173,771	25.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)					33
34	TOTAL (lines 1 - 33)	197,856	214,169	\$ 6,463,511 *	\$ 30.18	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	Monthly	\$ 111,563	1(3)	35
36	Medical Director	Monthly	22,400	9(7)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,638	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	Monthly	3,078	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 150,679		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	5,187	\$ 418,034	L10,C3	50
51	Licensed Practical Nurses	2,854	175,702	L10,C3	51
52	Certified Nurse Assistants/Aides	2,838	118,544	L10,C3	52
53	TOTAL (lines 50 - 52)	10,879	\$ 712,280		53

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

** See instructions.

XIX. SUPPORT SCHEDULES											
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Roxanne Fear	Administrator	0	\$ 238,653	Workers' Compensation Insurance		\$ 102,000	IDPH License Fee		\$		
				Unemployment Compensation Insurance			Advertising: Employee Recruitment				
				FICA Taxes		451,989	Health Care Worker Background Check				
				Employee Health Insurance		720,280	(Indicate # of checks performed)				
				Employee Meals			Patient Background Checks	542	5,420		
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Dues & Subscription		2,890		
				Employee Retirement		166,291	Offset chamber dues		(375)		
				Dental Insurance		16,369					
				Disability Ins		13,489					
				Employee Life Insurance		10,052					
				Mobile Cell Phone		2,460					
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense			()	
(List each licensed administrator separately.)			\$ 238,653				PAC and Lobbying payments			()	
B. Administrative - Other							All non-allowable advertising			()	
Description			Amount				TOTAL (agree to Sch. V, line 20, col. 8)			\$ 7,935	
N/A			\$								
TOTAL (agree to Schedule V, line 17, col. 3)			\$								
(Attach a copy of any management service agreement)											
C. Professional Services							G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
			\$	N/A		\$	Out-of-State Travel		\$		
							In-State Travel				
							Seminar Expense		9,776		
						</					

XX. GENERAL INFORMATION:

- (1)

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

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

	Total
- (5)

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

\$ 60,269 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 452,168

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ Has any meal income been offset against related costs?

Yes Indicate the amount. \$ 10,685
- (12)

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
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: KPMG LLP

Yes
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes
- (15)

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.