

		FOR BHF USE					

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**2007**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2007)**

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:** 0027334

**Facility Name:** Milestone-Elmwood East

**Address:** 2642 Elmwood Road Rockford 61103  
 Number City Zip Code

**County:** Winnebago

**Telephone Number:** (815) 877-7001 **Fax #** (815) 654-6445

**HFS ID Number:** 362769801003

**Date of Initial License for Current Owners:** 10/14/1982

**Type of Ownership:**

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Hugh W. Lippitt **Telephone Number:** (815) 639-2806

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/06 to 06/30/07 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Hugh W. Lippitt</u>	
	(Title) <u>Senior Vice President &amp; C.F.O.</u>	
<b>Paid Preparer</b>	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) ( ) _____ Fax # ( ) _____	

**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

Facility Name & ID Number Milestone-Elmwood East

# 0027334 Report Period Beginning: 07/01/06 Ending: 06/30/07

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>12</u>	ICF/DD 16 or Less	<u>12</u>	<u>4,380</u>	6
7	<u>12</u>	TOTALS	<u>12</u>	<u>4,380</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>4,250</u>			<u>4,250</u>
14	TOTALS	<u>4,250</u>			<u>4,250</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.03%

D. How many bed-hold days during this year were paid by the Department? 46 (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)  
n/a

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 05/01/80

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 02/06/81 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/07 Fiscal Year: 06/30/07

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

Facility Name & ID Number Milestone-Elmwood East # 0027334 Report Period Beginning: 07/01/06 Ending: 06/30/07

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	19,736	1,832	716	22,284		22,284	22,284			1
2	Food Purchase		40,460		40,460		40,460	40,460			2
3	Housekeeping	14,170	11,461		25,631		25,631	25,631			3
4	Laundry		23		23		23	23			4
5	Heat and Other Utilities			12,140	12,140		12,140	12,140			5
6	Maintenance	15,330	10,938	929	27,197		27,197	27,197			6
7	Other (specify):* <b>Maintenance Fee</b>			7,800	7,800		7,800	(7,800)			7
8	<b>TOTAL General Services</b>	49,236	64,714	21,585	135,535		135,535	(7,800)	127,735		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	274,264	879	1,752	276,895		276,895	276,895			10
10a	Therapy										10a
11	Activities		2,760		2,760		2,760	2,760			11
12	Social Services	11,829			11,829		11,829	11,829			12
13	CNA Training										13
14	Program Transportation		3,572	73	3,645		3,645	3,645			14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	286,093	7,211	1,825	295,129		295,129	295,129			16
	<b>C. General Administration</b>										
17	Administrative	7,623		11,373	18,996	(4,619)	14,377	14,377			17
18	Directors Fees										18
19	Professional Services			1,932	1,932		1,932	1,932			19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	10,648	4,836	3,221	18,705	4,619	23,324	(113)	23,211		21
22	Employee Benefits & Payroll Taxes			61,017	61,017		61,017	61,017			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			4,349	4,349		4,349	4,349			26
27	Other (specify):* <b>Management Fee</b>			3,240	3,240		3,240	(3,240)			27
28	<b>TOTAL General Administration</b>	18,271	4,836	85,132	108,239		108,239	(3,353)	104,886		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	353,600	76,761	108,542	538,903		538,903	(11,153)	527,750		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Milestone-Elmwood East #0027334 Report Period Beginning: 07/01/06 Ending: 06/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			7,142	7,142	624	7,766	(1,860)	5,906		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			14,220	14,220		14,220	798	15,018		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds			20,420	20,420		20,420	(20,420)			34
35	Rent-Equipment & Vehicles			369	369	(369)					35
36	Other (specify):* Alloc. Maint Bldg			255	255	(255)					36
37	<b>TOTAL Ownership</b>			42,406	42,406		42,406	(21,482)	20,924		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			33,652	33,652		33,652		33,652		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>			33,652	33,652		33,652		33,652		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	353,600	76,761	184,600	614,961		614,961	(32,635)	582,326		45

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

Facility Name & ID Number Milestone-Elmwood East

# 0027334

Report Period Beginning: 07/01/06

Ending: 06/30/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(20,420)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	135	30		9
10	Interest and Other Investment Income	(96)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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 5-A	(11,153)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (31,534)</b>		<b>\$</b>	<b>30</b>

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule See page 26	894	32	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 894</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (30,640)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

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

BHF USE ONLY					
48		49		50	51
					52

Milestone-Elmwood East

ID# 0027334

Report Period Beginning: 07/01/06

Ending: 06/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Management Fee	\$ (3,240)	27	1
2	Maintenance Fee	(7,800)	7	2
3	Correct Allocation	(113)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(11,153)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Milestone-Elmwood East

# 0027334

Report Period Beginning:

07/01/06

Ending:

06/30/07

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(7,800)	0	0	0	0	0	0	0	0	0	0	(7,800)	7
8	<b>TOTAL General Services</b>	<b>(7,800)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,800)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(113)	0	0	0	0	0	0	0	0	0	0	(113)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(3,240)	0	0	0	0	0	0	0	0	0	0	(3,240)	27
28	<b>TOTAL General Administration</b>	<b>(3,353)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,353)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(11,153)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,153)</b>	<b>29</b>

STATE OF ILLINOIS

Facility Name & ID Number Milestone-Elmwood East

# 0027334

Report Period Beginning:

07/01/06 Ending:

Summary B

06/30/07

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	135	0	0	0	0	0	0	0	0	0	0	135	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	798	0	0	0	0	0	0	0	0	0	0	798	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(20,420)	0	0	0	0	0	0	0	0	0	0	(20,420)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(19,487)</b>	<b>0</b>	<b>(19,487)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(30,640)</b>	<b>0</b>	<b>(30,640)</b>	<b>45</b>									

Facility Name & ID Number Milestone-Elmwood East

# 0027334

Report Period Beginning:

07/01/06

Ending:

06/30/07

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See page 24 & 25						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	See page 27	\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							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		\$			\$	\$ *	14

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

Facility Name & ID Number Milestone-Elmwood East # 0027334 Report Period Beginning: 07/01/06 Ending: 06/30/07

## 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 Milestone-Elmwood East

# 0027334

Report Period Beginning: 07/01/06

Ending: 06/30/07

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 Milestone, Inc.-Central Office  
 Street Address 4060 McFarland Road  
 City / State / Zip Code Rockford, IL 61111  
 Phone Number ( 815) 654-6100  
 Fax Number ( 815) 654-6444

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	1	Dietary Wages	Days	57,670	4	\$ 259,867	\$ 4,380	\$ 19,737	1
2	1	Dietary Supplies	Days	115,340	33	48,393	4,380	1,838	2
3	2	Food Purchase	Days	115,340	33	1,065,483	4,380	40,461	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	225,532	8,760	14,170	4
5	6	Maintenance Wages	Level of Care/Days	279,590	33	489,105	8,760	15,324	5
6	17	Administrative-Other	Level of Care/Days	8,904,480	39	321,102	315,360	11,372	6
7	21	Clerical Wages	Level of Care/Days	8,904,480	39	300,512	315,360	10,643	7
8	21	Office Supplies	Level of Care/Days	8,904,480	39	133,373	315,360	4,724	8
9	21	Telephone	Level of Care/Days	8,904,480	39	86,635	315,360	3,068	9
10	22	Fringe Benefits	Wages	14,870,880	40	2,566,002	353,600	61,014	10
11	35	Rent-Computer	Level of Care/Days	8,904,480	39	10,537	315,360	373	11
12	36	Rent Maintenance Bldg	Level of Care/Days	8,904,480	39	7,296	315,360	258	12
13									13
14									14
15		See Addendum A							15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 5,513,837	\$ 1,275,016	\$ 182,982	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	U.S. Dept. of HUD		X	Mortgage	\$1,928.00	10/1/80	\$ 288,847	\$ 181,740	10/1/20	7.6250	\$ 14,126	1								
2												2								
3												3								
4												4								
5												5								
<b>Working Capital</b>																				
6	Amcore Bank N.A., Rockford		X		N/A	7/23/01	2,500,000		1/10/08	8.2500	94	6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>				\$1,928.00		\$ 2,788,847	\$ 181,740			\$ 14,220	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 2,788,847	\$ 181,740			\$ 14,220	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Milestone-Elmwood East COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0027334

CONTACT PERSON REGARDING THIS REPORT Hugh W. Lippitt

TELEPHONE (815) 639-2806 FAX #: (815) 654-6444

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
<b>TOTALS</b>		\$	\$

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Milestone-Elmwood East

# 0027334 Report Period Beginning:

07/01/06 Ending:

06/30/07

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 5,565 B. General Construction Type: Exterior Brick Frame Cement Block Number of Stories one

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Project</u>	<u>64,925</u>	<u>1979</u>	<u>\$ 11,726</u>	1
2					2
3	<b>TOTALS</b>	<b>64,925</b>		<b>\$ 11,726</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	12		1980	1980	\$ 277,049	\$ 2,125	50	\$ 2,260	\$ 135	\$ 178,092	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Replace patio door		1995	2,688	179	15	179		2,120	9
10		Fire Alarm System		1998	1,550	78	20	78		730	10
11		Windows		1999	8,616	574	15	574		4,691	11
12		Roof Repair		1999	4,540	227	20	227		1,741	12
13		Floor Coverings		1999	5,759		5			5,759	13
14		Carpet		2001	2,527		5			2,527	14
15		Sidewalk Repair		2001	2,695	135	20	135		820	15
16		Landscaping		1992	3,830		10			3,830	16
17		Water Heater		1993	1,526		10			1,526	17
18		Blacktop		1994	7,070	471	15	471		6,167	18
19		Cement		1994	1,950	98	20	98		1,260	19
20		Water Line		1997	4,890	326	15	326		3,125	20
21		Carpet		2001	2,600	44	10	44		2,600	21
22		Water Heater		2003	2,729	273	10	273		1,160	22
23		Replace cabinets and doors in bathrooms		2003	2,784	186	15	186		712	23
24		Bathroom Countertop		2003	3,742	249	15	249		956	24
25		Cabinets		2003	2,064	138	15	138		505	25
26		Counter Top		2003	2,413	161	15	161		590	26
27		Sidewalk Repair		2004	7,060	282	25	282		565	27
28		Furnace		2006	2,695	135	20	135		157	28
29		Allocated Maintenance Building				255		255			29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Milestone-Elmwood East

# 0027334

Report Period Beginning:

07/01/06

Ending:

06/30/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	350,777	\$	5,936	\$	6,071	\$	135	\$	219,633	70

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

Facility Name & ID Number Milestone-Elmwood East # 0027334 Report Period Beginning: 07/01/06 Ending: 06/30/07

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 5,464	\$ 467	\$ 467	\$	10 yrs	\$ 5,190	71
72	Current Year Purchases	3,774	377	377		10 yrs	377	72
73	Fully Depreciated Assets	47,532				5-10 yrs	47,532	73
74	Central Office Computer		369	369				74
75	TOTALS	\$ 56,770	\$ 1,213	\$ 1,213	\$		\$ 53,099	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1999 Ford Van	1998	\$ 23,766	\$	\$	\$	3	\$ 23,766	76
77	Patient Care	2007 Ford Van	2007	22,229	617	617		3	617	77
78										78
79	Gain on Sale of Vehicle	1995 Ford Van	1,995							79
80	TOTALS			\$ 45,995	\$ 617	\$ 617	\$ (1,995)		\$ 24,383	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)		\$ 465,268	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 7,766	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 5,906	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (1,860)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 297,115	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	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending                      Annual Rent

12.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	<b>TOTAL</b>		\$ _____	\$ _____	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

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

Facility Name & ID Number Milestone-Elmwood East# 0027334Report Period Beginning: 07/01/06

Ending:

06/30/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 19,899	\$ 1,434,850	1
2	Cash-Patient Deposits	4,963	161,121	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	83,197	2,380,978	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		1,346	6
7	Other Prepaid Expenses		20,026	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other A/R</u>	419	24,034	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 108,478	\$ 4,022,355	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	11,726	1,360,490	13
14	Buildings, at Historical Cost	334,281	17,489,684	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	102,765	5,558,035	16
17	Accumulated Depreciation (book methods)	(331,757)	(13,553,582)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		110,273	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(110,273)	20
21	Restricted Funds		1,347,000	21
22	Other Long-Term Assets (spe Escrow & loan fees)		4,103,941	22
23	Other(specify): <u>Value Life Ins. &amp; Const. In prog</u>		223,691	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 117,015	\$ 16,529,259	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 225,493	\$ 20,551,614	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,109	\$ 478,716	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,963	161,121	28
29	Short-Term Notes Payable		161,803	29
30	Accrued Salaries Payable		561,636	30
31	Accrued Taxes Payable (excluding real estate taxes)		194,558	31
32	Accrued Real Estate Taxes(Sch.IX-B)		243	32
33	Accrued Interest Payable	1,155	173,933	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Pension,Wrkms Comp,Sec Dep,etc.</u>	1,592	571,951	36
37	<u>Intercompany A/P</u>	(270,642)		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ (261,823)	\$ 2,303,961	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	181,740	2,802,460	40
41	Bonds Payable		6,250,000	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 181,740	\$ 9,052,460	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ (80,083)	\$ 11,356,421	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 305,576	\$ 9,195,193	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 225,493	\$ 20,551,614	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 278,795	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 278,795	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	26,781	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 26,781</b>	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 305,576</b>	24 *

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

Facility Name &amp; ID Number Milestone-Elmwood East

# 0027334

Report Period Beginning: 07/01/06

Ending: 06/30/07

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 574,078	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 574,078	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	33,967	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	20,566	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 54,533	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	96	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 96	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Management/Maintenance Fee (see page 28)</b>	11,040	28
28a	<b>Gain on Sale of Vehicle</b>	1,995	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 13,035	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 641,742	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	135,535	31
32	Health Care	295,129	32
33	General Administration	108,239	33
<b>B. Capital Expense</b>			
34	Ownership	42,406	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	33,652	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 614,961	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	26,781	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 26,781	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. See Page 28

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

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

Facility Name & ID Number Milestone-Elmwood East

# 0027334

Report Period Beginning: 07/01/06

Ending:

06/30/07

**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	
2	Assistant Director of Nursing				2	
3	Registered Nurses	722	864	21,277	24.63	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	681	782	11,829	15.13	11
12	Dietician					12
13	Food Service Supervisor	92	119	3,059	25.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,407	1,582	16,678	10.54	15
16	Dishwashers					16
17	Maintenance Workers	975	1,102	15,330	13.91	17
18	Housekeepers	1,326	1,511	14,170	9.38	18
19	Laundry					19
20	Administrator	204	233	7,623	32.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	539	621	10,648	17.15	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,645	2,998	50,396	16.81	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	16,510	18,190	202,590	11.14	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	25,101	28,002	\$ 353,600 *	\$ 12.63	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	24	\$ 716	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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) <u>Dental</u>	35	1,752	10-3	46
47	<u>Clerical</u>	12	150	21-3	47
48					48
49	TOTAL (lines 35 - 48)	71	\$ 2,618		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





**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? no  
If YES, give association name and amount. \_\_\_\_\_
- (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? \_\_\_\_\_
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a Line \_\_\_\_\_
- (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. \_\_\_\_\_
- (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 x NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Milestone, Inc.-Elmwood East C.L.F. License #200321
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 33,652  
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. \$ n/a Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (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? 100%
- 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? yes
- 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.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: Lindgren, Callihan, VanOsdol Ltd. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? n/a  
Attach invoices and a summary of services for all architect and appraisal fees.

**SCHEDULE VII-A: BOARD MEMBER LISTING**

<u>NAME</u>	<u>TITLE</u>	<u>TYPE OF SERVICE PROVIDED TO FACILITY</u>	<u>OWNERSHIP INTEREST IN</u>
Patrick Agnew	Director	Legal	Agnew Law Office
Ronald Alden	Treasurer	Pension Accounting	McGladrey & Pullen
George Bass	Director	Insurance	Country Ins. & Financial Group
Thomas Budd	Vice Chairperson	N/A	Rockford Bank & Trust
Lyla DeVerdi	Director	N/A	
Alan Furman	Director	N/A	
James Hamilton	President & C.E.O.	Administrative Services	
Peggy Hanson	Secretary	N/A	
Jack Kieckhefer	Director	Insurance	Kieckhefer & Nelson
Cyrus Oates	Director	N/A	
Randy L. Cooper	Director	Insurance	Williams Manny
Tom Sandquist	Chairperson	Legal	Williams & McCarthy
Shawn Way	Director	N/A	Rockford Bank & Trust
Audrey Wickstrand	Director	N/A	

**SCHEDULE VII-A: RELATED PARTIES**

<u>MILESTONE, INC.</u>	<u>RESIDENTIAL BEDS</u>	<u>CITY</u>	<u>TYPE OF BUSINESS</u>
Central Office	N/A	Rockford	Central Office
Elmwood Heights	84	Rockford	ICF/MR-SLC
Elmwood East	12	Rockford	ICF/DD<16 & Fewer
Searles	12	Rockford	ICF/DD<16 & Fewer
Sun Valley	8	Rockford	ICF/DD<16 & Fewer
Javelin I (closed 8/15/06)	8	Rockford	C.R.A. - Waiver/C.I.L.A. Services
Applewood	8	Loves Park	C.R.A. - Waiver/C.I.L.A. Services
Orchard	8	Rockford	C.R.A. - Waiver/C.I.L.A. Services
Training Center	N/A	Rockford	Developmental Training
Industries	N/A	Loves Park	Developmental Training
RocVale Childrens Home	50	Rockford	Child Care Institute/DCFS
Shattuck	5	Rockford	C.I.L.A. Services
Eggleston	5	Rockford	C.I.L.A. Services
Dierks	8	Rockford	C.I.L.A. Services
Geneva	5	Rockford	C.I.L.A. Services
C.I.L.A.	21	Rockford	C.I.L.A. Services
Auburn	9	Rockford	C.I.L.A. Services
Park Terrace	9	Rockford	C.I.L.A. Services
Windcloud	5	Rockford	C.I.L.A. Services
Prospect	5	Rockford	C.I.L.A. Services
Hanford	5	Rockford	C.I.L.A. Services
Rural	5	Rockford	C.I.L.A. Services
Flintridge	5	Rockford	C.I.L.A. Services
Old Golf	4	Loves Park	C.I.L.A. Services
Creekside	5	Rockford	C.I.L.A. Services
Hermitage	5	Rockford	C.I.L.A. Services
Javelin II	5	Rockford	C.I.L.A. Services
Windpoint	5	Rockford	C.I.L.A. Services
Weymouth	5	Rockford	C.I.L.A. Services
Fleetwood	5	Rockford	C.I.L.A. Services
Stornway	5	Rockford	C.I.L.A. Services
Shiloh	4	Rockford	C.I.L.A. Services
Black Oak	5	Rockford	C.I.L.A. Services
Donna Drive	8	Rockford	C.I.L.A. Services
Respite Services	N/A	Rockford	Respite Services
Sawgrass	6	Rockford	C.I.L.A. Services
Crested Butte	6	Rockford	C.I.L.A. Services
Dental Program	N/A	Rockford	Dental Services
Thyme	6	Rockford	C.I.L.A. Services
Tulip	5	Rockford	C.I.L.A. Services
Packard	5	Rockford	C.I.L.A. Services
Country Club	5	Rockford	C.I.L.A. Services
HUD Project #071-EH003	N/A	Rockford	Housing
HUD Project #071-EH059	N/A	Rockford	Housing
HUD Project #071-EH178	N/A	Rockford	Housing
Bingo & Pull Tabs	N/A	Rockford	Bingo & Pull Tabs

### Interest Expense

Mortgage loan with the U.S. Department of Housing and Urban Development on the Strathmoor and Elmwood East buildings has been restated to conform with the I.D.P.A. field audit by Bercoom, Weiner, Glick and Brook for FY 1984. The book method valued each building at 50% of the mortgage. The field audit valued the Elmwood East portion at 53.1652% of the total.

	<u>TOTAL</u>	<u>50% on Books</u>	<u>53.1652% per Audit</u>	<u>Adjustment</u>
Original Loan Balance	543,300	271,650	288,847	
Current Balance	363,480	181,740	193,245	
Current Period Interest	28,252	14,126	15,020	894

**RECLASSIFICATION - SCHEDULE V. COLUMN 5**

SCHEDULE

V

<u>Line #</u>	<u>Title</u>	<u>Amount</u>
17	Administrative	(4,619.00)
21	Clerical	4,619.00
		<hr/> 0 <hr style="border-top: 1px dashed black;"/>

To reclassify accountant & secretary from administrative personnel purchased at cost from Milestone Foundation, Inc.

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30	Depreciation	369.00
35	Equipment Rent	(369.00)
		<hr/> 0 <hr style="border-top: 1px dashed black;"/>

To reclassify rental of Computer from Milestone, Inc. Central Office.

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30	Depreciation	255.00
36	Rent-Maintenance Building	(255.00)
		<hr/> 0 <hr style="border-top: 1px dashed black;"/>

To reclassify rental of Maintenance Building from Milestone, Inc. Central Office.

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### Schedule of Federal Form 990 Reconciliation

Page 19, Line 41	\$26,781
Related Organizations Net Income	486,668
Federal Form 990 Net Income	\$513,449

NOTE: The U.S. Department of Housing and Urban Development (HUD) mandates that we maintain a separate general ledger for each project built with their funds. This report consolidates the Elmwood East Program general ledger and the HUD Elmwood East Building general ledger. This consolidation necessitates the following consolidation elimination entries for transactions between the two inter-related entities:

<u>Page</u>	<u>Line</u>	<u>Column</u>	<u>Description</u>	<u>DR / (CR)</u>
3	7	7	Maintenance Fee Expense	(7,800)
3	27	7	Management Fee Expense	(3,240)
19	28a	1	Management/Maintenance Fee Revenue	11,040
4	34	7	Rent Expense - Facility	(20,420)
19	16	1	Rent Revenue - Facility	20,420

In compliance with the instructions, the following revenue items have been offset against expenses:

<u>Page</u>	<u>Line</u>	<u>Column</u>	<u>Description</u>	<u>DR / (CR)</u>
4	32	7	Interest Expense	(96)
19	25	1	Interest Income	96

(see also page 5, line 10, column 1)

**ADDENDUM  
A**