

Facility Name & ID Number Milestone-Elmwood East

0027334 Report Period Beginning: 07/01/08 Ending: 06/30/09

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	12	ICF/DD 16 or Less	12	4,380	6
7	12	TOTALS	12	4,380	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,187			4,187	13
14	TOTALS	4,187			4,187	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.59%

D. How many bed-hold days during this year were paid by the Department? 157 (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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/09 Fiscal Year: 06/30/09

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

Facility Name & ID Number Milestone-Elmwood East # 0027334 Report Period Beginning: 07/01/08 Ending: 06/30/09

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	18,530	2,373	996	21,899		21,899		21,899		1
2	Food Purchase		39,181		39,181		39,181		39,181		2
3	Housekeeping	13,461	1,093	124	14,678		14,678		14,678		3
4	Laundry										4
5	Heat and Other Utilities			11,398	11,398		11,398		11,398		5
6	Maintenance	16,341	8,456	1,229	26,026		26,026		26,026		6
7	Other (specify):* Maint. Fee			8,264	8,264		8,264	(8,264)			7
8	TOTAL General Services	48,332	51,103	22,011	121,446		121,446	(8,264)	113,182		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	254,967	791	1,752	257,510		257,510		257,510		10
10a	Therapy										10a
11	Activities		1,857		1,857		1,857		1,857		11
12	Social Services	13,367			13,367		13,367		13,367		12
13	CNA Training										13
14	Program Transportation		2,801	51	2,852		2,852		2,852		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	268,334	5,449	1,803	275,586		275,586		275,586		16
	C. General Administration										
17	Administrative	8,738			8,738		8,738		8,738		17
18	Directors Fees										18
19	Professional Services			3,467	3,467		3,467	(1,296)	2,171		19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	18,201	4,704	3,606	26,511		26,511		26,511		21
22	Employee Benefits & Payroll Taxes			67,542	67,542		67,542		67,542		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,795	1,795		1,795		1,795		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			4,302	4,302		4,302		4,302		26
27	Other (specify):* Mgmt Fee			4,032	4,032		4,032	(4,032)			27
28	TOTAL General Administration	26,939	4,704	84,744	116,387		116,387	(5,328)	111,059		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	343,605	61,256	108,558	513,419		513,419	(13,592)	499,827		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:

07/01/08

Ending:

06/30/09

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			14,286	14,286	809	15,095	135	15,230			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,414	13,414		13,414	725	14,139			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			21,571	21,571		21,571	(21,571)				34
35	Rent-Equipment & Vehicles			368	368	(368)						35
36	Other (specify):* Alloc. Maint. Bldg			441	441	(441)						36
37	TOTAL Ownership			50,080	50,080		50,080	(20,711)	29,369			37
	Ancillary Expense											
	E. Special Cost Centers											
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			31,841	31,841		31,841		31,841			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			31,841	31,841		31,841		31,841			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	343,605	61,256	190,479	595,340		595,340	(34,303)	561,037			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(21,571)	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	(90)	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 5A	(13,592)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,118)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule see page 26	815	32	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 815		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (34,303)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

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ID# 0027334

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Management Fee	\$ (4,032)	27	1
2	Maintenance Fee	(8,264)	7	2
3	Bookkeeping/Computer Fee	(1,296)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(13,592)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Milestone-Elmwood East# 0027334

Report Period Beginning:

07/01/08

Ending:

06/30/09

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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):*	(8,264)	0	0	0	0	0	0	0	0	0	0	(8,264)	7
8	TOTAL General Services	(8,264)	0	(8,264)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,296)	0	0	0	0	0	0	0	0	0	0	(1,296)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(4,032)	0	0	0	0	0	0	0	0	0	0	(4,032)	27
28	TOTAL General Administration	(5,328)	0	(5,328)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,592)	0	(13,592)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Milestone-Elmwood East# 0027334

Report Period Beginning:

07/01/08 Ending:06/30/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	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	725	0	0	0	0	0	0	0	0	0	0	725	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(21,571)	0	0	0	0	0	0	0	0	0	0	(21,571)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(20,711)	0	0	0	0	0	0	0	0	0	0	(20,711)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(34,303)	0	0	0	0	0	0	0	0	0	0	(34,303)	45

Facility Name & ID Number

Milestone-Elmwood East

0027334

Report Period Beginning:

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Ending:

06/30/09

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 pages 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: 07/01/08 Ending: 06/30/09

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

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Ending: 06/30/09

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	\$ 243,979	\$ 243,979	4,380	\$ 18,530	1
2	1	Dietary Supplies	Days	117,530	34	63,573	0	4,380	2,369	2
3	2	Food Purchase	Days	117,530	34	1,051,280	0	4,380	39,178	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	214,240	214,240	8,760	13,460	4
5	6	Maintenance Wages	Level of Care/Days	283,970	34	529,609	529,609	8,760	16,338	5
6	21	Clerical Wages	Level of Care/Days	9,009,600	36	440,127	440,127	315,360	15,406	6
7	21	Office Supplies	Level of Care/Days	9,009,600	36	134,332	0	315,360	4,702	7
8	21	Telephone	Level of Care/Days	9,009,600	36	98,063	0	315,360	3,432	8
9	22	Fringe Benefits	Wages	15,385,697	41	3,024,579	0	343,605	67,547	9
10	35	Rent-Computer	Level of Care/Days	9,009,600	36	10,402	0	315,360	364	10
11	36	Rent Maintenance Bldg	Level of Care/Days	9,009,600	36	12,718	0	315,360	445	11
12										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					\$ 5,822,902	\$ 1,427,955		\$ 181,771	25

Facility Name & ID Number

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0027334

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07/01/08

Ending:

06/30/09

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										
										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		X	Mortgage	\$1,928.00	5/8/80	\$ 288,847	\$ 164,739	10/1/20	7.6250	\$ 12,874	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6		X	Line of Credit		7/24/08	2,500,000		7/24/09	7.2500	540	6								
7											7								
8											8								
9	TOTAL Facility Related			\$1,928.00		\$ 2,788,847	\$ 164,739			\$ 13,414	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 2,788,847	\$ 164,739			\$ 13,414	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.)

Facility Name & ID Number Milestone-Elmwood East

0027334

Report Period Beginning:

07/01/08

Ending:

06/30/09

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).

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:

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

Facility Name & ID Number Milestone-Elmwood East

0027334

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	12		1980	1980	\$ 277,049	\$ 2,125	50	\$ 2,260	\$ 135	\$ 182,612	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Replace patio door	1995		2,688	179	15	179		2,478	9
10		Fire Alarm System	1998		1,550	78	20	78		885	10
11		Windows	1999		8,616	574	15	574		5,840	11
12		Roof Repair	1999		4,540	227	20	227		2,195	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		1,089	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	432	15	432		7,070	18
19		Cement	1994		1,950	97	20	97		1,455	19
20		Water Line	1997		4,890	326	15	326		3,777	20
21		Carpet	2001		2,600		10			2,600	21
22		Water Heater	2003		2,729	273	10	273		1,706	22
23		Replace cabinets and doors in bathrooms	2003		2,784	186	15	186		1,083	23
24		Bathroom Countertop	2003		3,742	249	15	249		1,455	24
25		Cabinets	2003		2,064	138	15	138		780	25
26		Counter Top	2003		2,413	161	15	161		911	26
27		Sidewalk Repair	2004		7,060	282	25	282		1,129	27
28		Furnace	2006		2,695	135	20	135		427	28
29		Carpet	2008		6,016	902	5	902		902	29
30		allocated Maintenance Building				441		441			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

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)	\$ 356,793	\$ 6,940		\$ 7,075	\$ 135	\$ 232,036	70

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

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	\$ 3,774	\$ 377	\$ 377	\$	10 yrs	\$ 1,132	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	52,996				5-10 yrs	52,996	73
74	Central Office Computer		368	368				74
75	TOTALS	\$ 56,770	\$ 745	\$ 745	\$		\$ 54,128	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	2007 Ford Van	2007	\$ 22,229	\$ 7,410	\$ 7,410	\$	3	\$ 15,437	76
77										77
78										78
79										79
80	TOTALS			\$ 22,229	\$ 7,410	\$ 7,410	\$		\$ 15,437	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)	\$ 447,518	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,095	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,230	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 135	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 301,601	85

**

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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)	
TOTAL TRAINED	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	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

0027334

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06/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 31,883	\$ 1,592,024	1
2	Cash-Patient Deposits	10,682	285,540	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	151,213	2,649,566	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		3,395	6
7	Other Prepaid Expenses		19,326	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other A/R</u>	347	31,376	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 194,125	\$ 4,581,227	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	11,726	1,519,861	13
14	Buildings, at Historical Cost	340,297	19,409,575	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	78,999	5,872,712	16
17	Accumulated Depreciation (book methods)	(335,975)	(15,063,059)	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		1,027,000	21
22	Other Long-Term Assets (spe <u>Escrow & loan fees</u>)		568,858	22
23	Other(specify): <u>CSV Life Ins. & Const in Prog</u>		189,793	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 95,047	\$ 13,524,740	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 289,172	\$ 18,105,967	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 394	\$ 510,033	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,682	285,540	28
29	Short-Term Notes Payable		201,006	29
30	Accrued Salaries Payable		739,168	30
31	Accrued Taxes Payable (excluding real estate taxes)		70,614	31
32	Accrued Real Estate Taxes(Sch.IX-B)		921	32
33	Accrued Interest Payable	1,047	76,382	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Pension,Wrkmsns Comp,Sec Dep, etc.</u>	1,704	497,395	36
37	<u>Intercompany A/P</u>	(285,442)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (271,615)	\$ 2,381,059	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	164,739	2,929,683	40
41	Bonds Payable		2,665,000	41
42	Deferred Compensation		201,457	42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 164,739	\$ 5,796,140	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (106,876)	\$ 8,177,199	46
47	TOTAL EQUITY(page 18, line 24)	\$ 396,048	\$ 9,928,768	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 289,172	\$ 18,105,967	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 333,736	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 333,736	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	62,312	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)	\$ 62,312	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)	\$ 396,048	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Milestone-Elmwood East

0027334

Report Period Beginning: 07/01/08

Ending: 06/30/09

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 578,722	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 578,722	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	39,673	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	21,580	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	3,995	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 65,248	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	90	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 90	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management & Maintenance Fee	12,296	28
28a	Bookkeeping/Computer Fee	1,296	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,592	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 657,652	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	121,446	31
32	Health Care	275,587	32
33	General Administration	116,386	33
B. Capital Expense			
34	Ownership	50,080	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	31,841	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 595,340	40
41	Income before Income Taxes (line 30 minus line 40)**	62,312	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 62,312	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

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07/01/08

Ending:

06/30/09

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	693	774	17,153	22.16	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	680	782	13,367	17.09	11
12	Dietician					12
13	Food Service Supervisor	98	119	3,029	25.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,347	1,488	15,501	10.42	15
16	Dishwashers					16
17	Maintenance Workers	970	1,094	16,341	14.94	17
18	Housekeepers	1,232	1,430	13,461	9.41	18
19	Laundry					19
20	Administrator	196	233	8,738	37.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	646	737	15,413	20.91	23
24	Clerical	219	257	2,788	10.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,070	2,347	40,776	17.37	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	16,884	18,295	197,038	10.77	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	25,035	27,556	\$ 343,605 *	\$ 12.47	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	25	\$ 996	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>	13	165	21-3	47
48					48
49	TOTAL (lines 35 - 48)	73	\$ 2,913		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

Facility Name & ID Number Milestone-Elmwood East

0027334

Report Period Beginning: 07/01/08

Ending: 06/30/09

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? n/a
- (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. \$ 31,841
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.
- (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	Vice Chairperson	Pension Accounting	McGladrey & Pullen
George Bass	Director	Insurance	Country Ins. & Financial Group
Thomas Budd	Chairperson	Financial	Rockford Bank & Trust
Alan W. Bjork	Director	N/A	
Lyla DeVerdi	Director	N/A	
Alan Furman	Director	N/A	
James Hamilton	President & C.E.O.	Administrative Services	
Peggy Hanson	Director	N/A	
Jack Kieckhefer	Director	Insurance	Kieckhefer & Nelson
Cyrus Oates	Director	N/A	
Randy L. Cooper	Secretary	Insurance	Williams Manny
Tom Sandquist	Director	Legal	Williams & McCarthy
Shawn Way	Director	Financial	Rockford Bank & Trust
Audrey Wickstrand	Director	N/A	

SCHEDULE VII-A: RELATED PARTIES

<u>MILESTONE, INC.</u>	RESIDENTIAL <u>BEDS</u>	<u>CITY</u>	TYPE OF <u>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
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
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.	22	Rockford	C.I.L.A. Services
Oleson	9	Rockford	C.I.L.A. Services
Park Terrace	7	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	8	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 (closed 10/10/08)	5	Rockford	C.I.L.A. Services
Southbridge (opened 7/14/08)	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	329,478	164,739	175,168	
Current Period Interest	25,748	12,874	13,689	815

RECLASSIFICATION - SCHEDULE V. COLUMN 5

SCHEDULE
V
Line #

Title

Amount

30	Depreciation	368.00
35	Equipment Rent	(368.00)
		<u>0</u>

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

30	Depreciation	441.00
36	Rent-Maintenance Building	(441.00)
		<u>0</u>

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

Schedule of Federal Form 990 Reconciliation

Page 19, Line 41	\$62,312
Related Organizations Net Income	798,245
Federal Form 990 Net Income	<u>\$860,557</u>

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	(8,264)
3	27	7	Management Fee Expense	(4,032)
3	19	7	Bookkeeping/Computer Fee	(1,296)
19	29	1	Management/Maintenance Fee Revenue	13,592
4	34	7	Rent Expense - Facility	(21,571)
19	16	1	Rent Revenue - Facility	21,571

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	(90)
19	25	1	Interest Income	90

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

SCHEDULE OF TRAVEL & SEMINAR EXPENSE

	<u>EMPLOYEE NAME</u>	<u>JOB TITLE</u>	<u>DATES</u>	<u>SEMINAR LOCATION</u>	<u>SEMINAR TITLE</u>	<u>SEMINAR SPONSOR</u>	<u>CHECK #</u>	<u>COST</u>
1.	Dana Harmon	QMRP	8/5/08 thru 8/8/08	Memphis, TN	13th Annual NAQ Conference	National Assoc. for QMRP's	117289 117705 116837	392.50 523.23 285.00
2.	Gabrielle Hendrix		12/19/08	Rockford, IL	Math, Reading	Rock Valley College	119135	594.00
							Total	<u>1,794.73</u>

**ADDENDUM
A**