



Facility Name & ID Number Milestone-Elmwood Heights

# 0024943 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	84	Intermediate/DD	84	30,660	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	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	30,333			30,333	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,333			30,333	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.93%

D. How many bed-hold days during this year were paid by the Department? 254 (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 09/04/79

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ 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 Heights # 0024943 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
	<b>A. General Services</b>										
1	Dietary	129,710	16,584	1,100	147,394		147,394		147,394		1
2	Food Purchase		274,247		274,247		274,247		274,247		2
3	Housekeeping	141,331	186,808	6,236	334,375		334,375		334,375		3
4	Laundry		25,693		25,693		25,693		25,693		4
5	Heat and Other Utilities			195,649	195,649		195,649		195,649		5
6	Maintenance	171,544	235,994	25,008	432,546		432,546		432,546		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	442,585	739,326	227,993	1,409,904		1,409,904		1,409,904		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,409,729	285,084	71,074	2,765,887		2,765,887		2,765,887		10
10a	Therapy			500	500		500		500		10a
11	Activities		32,982		32,982		32,982		32,982		11
12	Social Services										12
13	CNA Training	157,278			157,278		157,278		157,278		13
14	Program Transportation		29,384	3,956	33,340		33,340		33,340		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,567,007	347,450	93,530	3,007,987		3,007,987		3,007,987		16
	<b>C. General Administration</b>										
17	Administrative	61,164			61,164		61,164		61,164		17
18	Directors Fees										18
19	Professional Services			10,442	10,442		10,442		10,442		19
20	Dues, Fees, Subscriptions & Promotions			23,066	23,066		23,066		23,066		20
21	Clerical & General Office Expenses	137,865	32,914	24,027	194,806		194,806		194,806		21
22	Employee Benefits & Payroll Taxes			630,761	630,761		630,761		630,761		22
23	Inservice Training & Education			3,681	3,681		3,681		3,681		23
24	Travel and Seminar			11,829	11,829		11,829		11,829		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			49,293	49,293		49,293		49,293		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	199,029	32,914	753,099	985,042		985,042		985,042		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,208,621	1,119,690	1,074,622	5,402,933		5,402,933		5,402,933		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 &amp; ID Number

Milestone-Elmwood Heights

#0024943

Report Period Beginning:

07/01/08

Ending:

06/30/09

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			280,240	280,240	5,665	285,905	(101,092)	184,813			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,822	3,822		3,822		3,822			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,085	22,085	(2,549)	19,536		19,536			35
36	Other (specify):* Alloc. Maint Bldg			3,116	3,116	(3,116)						36
37	<b>TOTAL Ownership</b>			309,263	309,263		309,263	(101,092)	208,171			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			308,072	308,072		308,072		308,072			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			308,072	308,072		308,072		308,072			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,208,621	1,119,690	1,691,957	6,020,268		6,020,268	(101,092)	5,919,176			45

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



Milestone-Elmwood Heights

ID# 0024943

Report Period Beginning: 07/01/08

Ending: 06/30/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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>	0	49



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Milestone-Elmwood Heights# 0024943

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)	
	<b>D. Ownership</b>													
30	Depreciation	(101,092)	0	0	0	0	0	0	0	0	0	0	(101,092)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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>(101,092)</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>(101,092)</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>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(101,092)	0	0	0	0	0	0	0	0	0	0	(101,092)	45

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 &amp; ID Number

Milestone-Elmwood Heights

#

0024943

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

Facility Name & ID Number Milestone-Elmwood Heights

# 0024943

Report Period Beginning:

07/01/08

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

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

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

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	30,660	\$ 129,710	1
2	1	Dietary Supplies	Days	117,530	34	63,573	0	30,660	16,584	2
3	2	Food Purchase	Days	117,530	34	1,051,280	0	30,660	274,247	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	214,240	214,240	91,980	141,331	4
5	6	Maintenance Wages	Level of Care/Days	283,970	34	529,609	529,609	91,980	171,544	5
6	21	Clerical Wages	Level of Care/Days	9,009,600	36	440,127	440,127	2,207,520	107,839	6
7	21	Office Supplies	Level of Care/Days	9,009,600	36	134,332	0	2,207,520	32,914	7
8	21	Telephone	Level of Care/Days	9,009,600	36	98,063	0	2,207,520	24,027	8
9	22	Fringe Benefits	Wages	15,385,697	41	3,024,579	0	3,208,621	630,763	9
10	35	Rent-Computer	Level of Care/Days	9,009,600	36	10,402	0	2,207,520	2,549	10
11	36	Rent Maintenance Building	Level of Care/Days	9,009,600	36	12,718	0	2,207,520	3,116	11
12										12
13										13
14		See Addendum A								14
15										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		\$ 1,534,624	25

Facility Name & ID Number

Milestone-Elmwood Heights

# 0024943

Report Period Beginning:

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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1										1									
2										2									
3										3									
4										4									
5										5									
<b>Working Capital</b>																			
6	Rockford Bank & Trust	X	Line of Credit	N/A	07/24/08	2,500,000		07/24/09	7.2500	3,822	6								
7											7								
8											8								
9	<b>TOTAL Facility Related</b>					\$ 2,500,000	\$			\$ 3,822	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>					\$ 2,500,000	\$			\$ 3,822	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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

**2008 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Milestone-Elmwood Heights COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0024943

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

**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 Heights

# 0024943

Report Period Beginning:

07/01/08

Ending:

06/30/09

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 40,570 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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Project</u>	<u>261,356</u>	<u>1978</u>	<u>\$ 102,215</u>	<u>1</u>
2	<u>Recreational Land</u>	<u>304,947</u>	<u>1978</u>		<u>2</u>
3	<b>TOTALS</b>	<b>566,303</b>		<b>\$ 102,215</b>	<b>3</b>

Facility Name &amp; ID Number Milestone-Elmwood Heights

# 0024943

Report Period Beginning:

07/01/08

Ending:

06/30/09

**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	84		1980	1979	\$ n/a	\$ 94,122	30	\$	\$ (94,122)	\$ n/a	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Kitchen Design Plan		1978	550		5			550	9
10		Intercom System		1978	12,716		10			12,716	10
11		Door Locking System		1978	14,081		10			14,081	11
12		Floor Tile		1979	2,870		10			2,870	12
13		Landscaping		1980	25,659		5			25,659	13
14		Sign		1980	725		5			725	14
15		Chain Link Fence		1980	1,377		5			1,377	15
16		Landscaping		1980	4,071		5			4,071	16
17		Storage Building		1980	8,471		5			8,471	17
18		Landscaping		1981	595		5			595	18
19		Bike Path, Parking Lot, Basketball Court		1982	22,944		15			22,944	19
20		Parking Lot Repairs		1982	2,216		15			2,216	20
21		Room Remodeling		1983	4,312		10			4,312	21
22		Concrete Slab for Shelter		1984	6,751		15			6,751	22
23		Park Shelter		1984	13,058		15			13,058	23
24		Driveway Maintenance		1984	2,201		5			2,201	24
25		Sewer Repair		1984	1,195		20			1,195	25
26		Landscaping-Trees		1985	1,677		5			1,677	26
27		Landscaping-Plantscape		1986	4,117		10			4,117	27
28		Sidewalk Concrete		1988	2,930	51	20	51		2,930	28
29		Sidewalk Improvements		1990	5,490	275	20	275		5,285	29
30		Parking Lot		1990	3,097		15			3,097	30
31		Parking Lot Repairs		1991	2,430		15			2,430	31
32		Roof		1992	3,969	198	20	198		3,397	32
33		Outdoor Drinking Fountain		1992	1,998	100	20	100		1,708	33
34		Telephone System		1992	9,600		12			9,600	34
35		Roof Repairs		1993	6,965	348	20	348		5,485	35
36		Sump Pumps		1993	4,721		10			4,721	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 &amp; ID Number Milestone-Elmwood Heights

# 0024943

Report Period Beginning:

07/01/08

Ending:

06/30/09

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Furnace	1994	\$ 40,882	\$ 2,044	20	\$ 2,044	\$	\$ 29,989	37
38	Telephones	1994	3,111		12			3,111	38
39	Air Handler	1995	1,668		7			1,668	39
40	Above Ground Tank	1995	4,825	241	20	241		3,399	40
41	Concrete	1995	5,575	279	20	279		3,876	41
42	Furnace	1995	9,618	481	20	481		6,665	42
43	Roof	1995	1,290	65	20	65		888	43
44	Kitchen Sink	1995	1,300	65	20	65		889	44
45	Road Stone	1996	1,120		5			1,120	45
46	Air Conditioner	1996	2,476	124	20	124		1,579	46
47	Tile	1996	360		5			360	47
48	Sinks	1997	6,470	431	15	431		5,283	48
49	Flood Lights	1997	2,550	127	20	127		1,541	49
50	Air Conditioner	1997	4,055	203	20	203		2,451	50
51	Sidewalk	1997	6,691	335	20	335		4,015	51
52	Black Top Parking Lot	1997	85,125	5,675	15	5,675		68,100	52
53	Smoke Detectors	1997	16,100	1,073	15	1,073		12,700	53
54	Roof	1997	7,070	353	20	353		4,154	54
55	Counters	1997	3,706	247	15	247		2,862	55
56	Fire Alarm System	1998	3,660	183	20	183		2,089	56
57	Acoustical Ceiling	1998	1,650	82	20	82		943	57
58	Sidewalk Repair	1998	5,660	283	20	283		3,113	58
59	Duct Work	1998	1,017	51	20	51		560	59
60	Tile Repair	1998	650		5			650	60
61	Air Conditioner	1998	2,742	183	15	183		2,010	61
62	Carpet	1998	1,544		7			1,544	62
63	Driveway Repairs	1998	2,372	158	15	158		1,713	63
64	Roof	1998	2,000	100	20	100		1,075	64
65	Dry Valve	1998	1,540	39	10	39		1,540	65
66	Roof	1999	5,970	299	20	299		3,135	66
67	Dry Valve	1999	1,815	181	10	181		1,785	67
68	Tile	1999	2,600		5			2,600	68
69	Acoustical Ceiling	2000	6,750	338	20	338		3,064	69
70	TOTAL (lines 4 thru 69)		\$ 414,748	\$ 108,734		\$ 14,612	\$ (94,122)	\$ 348,710	70

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

Facility Name &amp; ID Number Milestone-Elmwood Heights

# 0024943

Report Period Beginning:

07/01/08

Ending:

06/30/09

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 414,748	\$ 108,734		\$ 14,612	\$ (94,122)	\$ 348,710	1
2	Carpet	2000	12,538		5			12,538	2
3	Counter Tops	2000	1,622	108	15	108		937	3
4	Automatic Doors	2002	4,148		5			4,148	4
5	Tile	2002	2,760		5			2,760	5
6	Water Heater	2002	4,200	420	10	420		3,115	6
7	Water Heater	2002	8,135		5			8,135	7
8	Carpet	2002	2,232		5			2,232	8
9	Tile	2002	2,160		5			2,160	9
10	Cabinets	2003	2,449	163	15	163		994	10
11	Sump Pump	2003	7,218	722	10	722		4,391	11
12	Carpet	2003	8,950		5			8,950	12
13	Air Conditioner	2003	4,705	470	10	470		2,823	13
14	Carpet	2003	5,309		5			5,310	14
15	Cabinets	2003	2,409	161	15	161		951	15
16	Water Heater	2003	3,694	185	5	185		3,694	16
17	Acoustical Ceilings	2004	11,040	552	15	552		3,036	17
18	Carpet	2004	2,094	299	7	299		1,645	18
19	Remove ceiling tile & install drywall ceilings	2004	20,380	1,359	15	1,359		7,359	19
20	Carpet	2004	5,058	723	7	723		3,794	20
21	Thermostatic control system for heat and air	2004	29,322	1,466	20	1,466		7,697	21
22	Heater	2004	4,660	466	10	466		2,407	22
23	Cabinets	2004	8,204	547	15	547		2,780	23
24	Carpet	2004	27,534	3,933	7	3,933		18,773	24
25	Smoke & Heat Detectors	2004	6,945	695	10	695		3,357	25
26	Vinyl Floor	2004	7,242	1,035	7	1,035		4,914	26
27	Vinyl Floor	2005	5,102	729	7	729		3,279	27
28	Cabinets	2005	20,031	1,335	15	1,335		5,719	28
29	Counter Tops	2005	3,097	207	15	207		912	29
30	Ceramic Tile	2005	3,377	482	7	482		2,050	30
31	Water Pipe Repair	2005	8,955	358	25	358		1,433	31
32	Roof	2005	6,425	321	20	321		1,285	32
33	Replace Sidewalk	2005	10,808	540	20	540		2,071	33
34	TOTAL (lines 1 thru 33)		\$ 667,551	\$ 126,010		\$ 31,888	\$ (94,122)	\$ 484,359	34

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

Facility Name &amp; ID Number Milestone-Elmwood Heights

# 0024943

Report Period Beginning:

07/01/08

Ending:

06/30/09

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 667,551	\$ 126,010		\$ 31,888	\$ (94,122)	\$ 484,359	1
2	Furnaces(8)	2006	20,135	1,007	20	1,007		3,366	2
3	Office Remodel	2006	3,870	258	15	258		860	3
4	Neo Flooring	2006	9,476	1,354	7	1,354		4,512	4
5	Cabinets	2006	20,176	1,345	15	1,345		4,372	5
6	Furnace & Air Conditioner	2006	3,295	165	20	165		522	6
7	Acoustical Ceiling	2006	6,000	300	20	300		950	7
8	Activity Room Remodel	2006	8,980	599	15	599		1,896	8
9	Vinyl Flooring	2006	4,418	631	7	631		1,999	9
10	Carpet	2006	22,509	3,216	7	3,216		8,676	10
11	Furnaces(4)	2006	12,861	643	20	643		1,715	11
12	Concrete Curb&Gutter	2006	14,906	745	20	745		1,952	12
13	Furnace	2007	9,162	458	20	458		992	13
14	Water Heater	2007	3,396	679	5	679		1,415	14
15	Carpet	2007	18,229	2,604	7	2,604		4,893	15
16	Vinyl Flooring	2007	6,135	876	7	876		1,607	16
17	Gas Water Heater	2007	5,184	1,037	5	1,037		1,901	17
18	Fire Suppression System	2007	3,325	332	10	332		582	18
19	Furnaces(4)	2007	9,514	476	20	476		793	19
20	Doors	2007	16,161	1,077	15	1,077		1,706	20
21	Carpet	2008	5,429	776	7	776		1,099	21
22	Blacktop Parking Lot	2007	78,292	5,219	15	5,219		6,959	22
23	Fans & Supplies	2008	6,849	257	20	257		257	23
24	Service Fire Alarm System	2008	6,848	514	10	514		514	24
25	Concrete Ramp	2008	4,136	155	20	155		155	25
26	Service Fire Alarm System	2009	3,370	84	10	84		84	26
27	Carpet	2009	17,562	624	5	624		624	27
28	Covered Walkway	2009	850,010	2,800	25	2,800		2,800	28
29	Blacktop Parking Lot	2009	11,142	62	15	62		62	29
30	Sidewalks	2009	6,704	28	20	28		28	30
31	Capital Grant Building			970			(970)		31
32	Allocated Maintenance Building			3,116		3,116			32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,855,625	\$ 158,417		\$ 63,325	\$ (95,092)	\$ 541,650	34

\*\*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	\$ 369,564	\$ 50,587	\$ 50,587	\$	5-15 yrs	\$ 196,181	71
72	Current Year Purchases	31,597	3,417	3,417		5-10 yrs	3,417	72
73	Fully Depreciated Assets	30,488				5-15 yrs	30,488	73
74	Allocated Computer System		2,549	2,549				74
75	TOTALS	\$ 431,649	\$ 56,553	\$ 56,553	\$		\$ 230,086	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	See page 30			\$ 511,955	\$ 70,935	\$ 64,935	\$ (6,000)		\$ 419,961	76
77										77
78										78
79										79
80	TOTALS			\$ 511,955	\$ 70,935	\$ 64,935	\$ (6,000)		\$ 419,961	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)	\$ 2,901,444	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 285,905	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 184,813	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (101,092)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,191,697	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: N/A

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

If NO, see instructions.  YES  NO

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

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

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

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

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

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

16. Rental Amount for movable equipment: \$ 11,443 Description: copier  YES  NO

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Program</u>	<u>2007 Lexus Sedan</u>	\$ <u>674.00</u>	\$ <u>8,093</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>674.00</u>	\$ <u>8,093</u>	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.

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/08 Ending: 06/30/09  
 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 checked="" type="checkbox"/> YES <input 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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)	15,691	27,587		43,278
4	Clinical Wages (b)	41,200	55,174		96,374
5	In-House Trainer Wages (c)	8,108	9,518		17,626
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 64,999	\$ 92,279	\$	\$ 157,278
10	SUM OF line 9, col. 1 and 2 (e)	\$ 157,278			

**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	74
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	63
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>137</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	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	<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 Heights# 0024943Report Period Beginning: 07/01/08Ending: 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	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 2,800	\$ 1,592,024	1
2	Cash-Patient Deposits	69,917	285,540	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,328,958	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):		31,376	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,401,675	\$ 4,581,227	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	102,215	1,519,861	13
14	Buildings, at Historical Cost	4,693,837	19,409,575	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,917,876	5,872,712	16
17	Accumulated Depreciation (book methods)	(4,907,793)	(15,063,059)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	81,448	110,273	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(81,448)	(110,273)	20
21	Restricted Funds		1,027,000	21
22	Other Long-Term Assets (spe Escrow & loan fees)		568,858	22
23	Other(specify): <u>Value Life Ins. &amp; Const. in prog</u>		189,793	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,806,135	\$ 13,524,740	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,207,810	\$ 18,105,967	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$ 510,033	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,917	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		76,382	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Pension,Wrkmsns Comp,Sec Dep, etc.</u>		497,395	36
37	<u>Intercompany A/P</u>	5,105,215		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 5,175,132	\$ 2,381,059	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,929,683	40
41	Bonds Payable		2,665,000	41
42	Deferred Compensation		201,457	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>	\$	\$ 5,796,140	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 5,175,132	\$ 8,177,199	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,967,322)	\$ 9,928,768	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,207,810	\$ 18,105,967	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,961,615)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,961,615)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(5,707)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(5,707)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,967,322)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Milestone-Elmwood Heights

# 0024943

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,695,585	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,695,585	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		10
11	CNA Training Reimbursements	312,896	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		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>	\$ 312,896	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Gain on sale of Vehicle &amp; Equipment</u>	6,080	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,080	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,014,561	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,409,904	31
32	Health Care	3,007,988	32
33	General Administration	985,041	33
<b>B. Capital Expense</b>			
34	Ownership	309,263	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	308,072	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,020,268	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(5,707)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (5,707)	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 Heights

# 0024943

Report Period Beginning:

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	2,220	2,560	\$ 68,730	\$ 26.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,333	7,125	166,988	23.44	3
4	Licensed Practical Nurses	14,968	16,820	339,767	20.20	4
5	CNAs & Orderlies					5
6	CNA Trainees	16,875	16,875	157,278	9.32	6
7	Licensed Therapist	503	503	33,129	65.86	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	687	832	21,199	25.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,428	10,417	108,511	10.42	15
16	Dishwashers					16
17	Maintenance Workers	10,187	11,482	171,544	14.94	17
18	Housekeepers	12,936	15,016	141,331	9.41	18
19	Laundry					19
20	Administrator	1,374	1,631	61,164	37.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,521	5,155	107,839	20.92	23
24	Clerical	2,342	2,759	30,026	10.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	27,161	30,743	496,816	16.16	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	119,301	129,267	1,304,299	10.09	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	228,836	251,185	\$ 3,208,621 *	\$ 12.77	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	28	\$ 1,100	1-3	35
36	Medical Director	120	18,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	55	1,925	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental</u>	245	12,264	10-3	46
47	<u>Psychologist/Psychiatrist</u>	444	50,965	10-3	47
48					48
49	TOTAL (lines 35 - 48)	892	\$ 84,254		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	173	\$ 5,921	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	173	\$ 5,921		53





Facility Name &amp; ID Number Milestone-Elmwood Heights

# 0024943

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? 5-10 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 \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 308,072  
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? no -see pg 29
- 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>	<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
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

**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.	Alex Ariri	RN	2/6/09 9/12/08	Bourbonnais, IL	Leadership/Mgmt in Nursing, Hlthcare Law, Faith & Contemporary Issues, Adv adult hlth Nrsg, Families in Crisis, The global Community	Olivet Nazarene	119670 117696	549.00 549.00
2.	Alexis Harper	Habilitation Aide	12/19/08	Rockford, IL	Psychology, Intro Human Biology	Rock Valley College	119134	396.00
3.	Amie Moist	QMRP	3/13/09 3/9/09	Carbondale, IL	Staff Training, Behavior Analysis, Legal & Ethical Research in Rehabilitation, Internship in Rehab	Southern IL University	120146 120062	366.00 732.00
4.	Julie Meyer	QMRP	8/5/08 - 8/8/08	Memphis, TN	13th Annual NAQ Conference	National Assoc. for QMRP's	117136	334.00
5.	Angelo Zammuto	Team Leader	8/1/08	Rockford, IL	History of US, Comp II, Intro to Ed, Physical Geo	Rock Valley College	117161	366.00
6.	April Adams	HR Assistant	10/3/08	Rockford, IL	Principles of Mgmt	Hudson University	118114	183.00
7.	Ashley Howell	Habilitation Aide	12/19/08	Rockford, IL	Intro Life Science, Comp I, Algebra, Orientation College	Rock Valley College	119139	594.00
8.	Ashlie Judd	Home Coordinator	8/8/08	Rockford, IL	Philosophy	Rockford College	117212	244.00
9.	Cheri Poage	Director of Nursing	12/19/08	Rockford, IL	General Psychology	Rock Valley College	119173	198.00
10.	Jill Morgan	Team Leader	10/28/08	Madison, WI	Let's Roll, The Art of Performing Seating & Mobility Evals	Cross Country Education	117952	189.00
11.	Taqwona Caldwell	Habilitation Aide	2/20/09	Rockford, IL	Basic Keyboarding, Psychology, College English	Rockford Career College	119854	594.00
12.	Terrie Garlow	QMRP	9/9/08	Northbrook, IL	The Aging Process in Persons with DD	Glenkirk	117277	585.00
	Amber Rasmussen	QMRP					117625	30.00
	Donald Shields	Nurse						
	Alex Ariri	Nurse						
	Denise Sneek	Nurse						
	Gene Engelkes	QMRP						
	Lauri Krull	QMRP						
	Becky Hinz	Nurse						
	Joanna Grahn	Admin.						

**SCHEDULE OF TRAVEL & SEMINAR EXPENSE**

13.	Shanta Goodloe	Habilitation Aide	2/20/09	Rockford, IL	College Career Skills, Quantatative Skills II	Rockford Career College	119874	528.00
14.	Amber Rasmussen	QMRP	Aug. 20 & 27 Sept. 3,10,17	Rockford, IL	QMRP Training	Goldie B. Floberg	117310	700.00
15.	Priscilla Macki	Receptionist	12/19/08	Rockford, IL	Math	Rock Valley College	119155	330.00
16.	Monique Evans	Habilitation Aide	12/19/08	Rockford, IL	Reading	Rock Valley College	119127	330.00
17.	Martin-Nique Sharp	Habilitation Aide	1/2/09	Freeport, IL	Medical Terminology I	Highland Community College	119298	198.00
18.	Yvonne Pena	Habilitation Aide	1/9/09 8/22/08	Rockford, IL	Psychology I&II, Math	Rock Valley College	119388 117468	198.00 366.00
19.	Linda Thornbloom Cheri Poage Brenda Wallace	Administrator Director of Nursing LPN	10/21/08	Rockford, IL	The Grieving Process	Northern Illinois Hospice	117980	120.00
20.	Delores Robison Estella Dandridge Shelly Deiter Laura Van	Home Coordinator Home Coordinator Team Leader Team Leader	9/23/08	Peoria, IL	One-on-One coaching mentoring	Employers' Association	118248	165.00
21.	Sahlee Burton Linda Hoffman	LPN LPN	10/16/08	Schaumburg, IL	Neurology Secrets	PESI Healthcare	118072	328.00
22.	Brenda Wallace Cheri Poage Vicki Chandler Peggy Jones Linda Craig Ellis	LPN Director of Nursing LPN LPN LPN	11/3/08	Rockford, IL	Gastrointestinal Conditions & Diseases	PESI Healthcare	117359 117777	328.00 492.00
23.	Lorenzo Mathis	LPN	9/17/08	Arlington Heights, IL	Nursing Documentation: Legally Proven Strategies to kep you out of the courtroom	PESI Healthcare	117143	328.00
24.	Amie Moist	QMRP	5/22/09	Machesney Park, IL	Behavioral Counseling: Assessment & Intervention Techniques	Assoc. for Behavioral Analysis Int.	122331	121.00
25.	Tom Cassady	Instructor	5/13/08	Chicago, IL	Dealing with Challenging Families	Alzheimers Association	122267	45.00

**SCHEDULE OF TRAVEL & SEMINAR EXPENSE**

26.	Linda Thornbloom	Administrator	6/23/09	Lisle, IL	New Quality of Life Revisions to LTC	Life Services Network	122577	85.00
27.	Jim Hamilton	President & CEO		Springfield, IL			119008	252.13
				Springfield, IL			118248	532.28
				Chicago, IL			120512	473.25
							Total	<u>#####</u>

**RECLASSIFICATION - SCHEDULE V. COLUMN 5**

SCHEDULE  
V

Line #	Title	Amount
30	Depreciation	2,549.00
35	Equipment Rent	(2,549.00)
		<u>0</u>
		-----

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

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30	Depreciation	3,116.00
36	Rent-Maintenance Building	(3,116.00)
		<u>0</u>
		-----

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	(\$5,707)
	\$866,264 Related Organizational Net Income
Federal Form 990 Net Income	<u>\$860,557</u>

**Schedule XX, Line 16 - E**

Due to the varied hours worked by the administrator (early morning and late evening meetings) he is allowed to take the company vehicle home at night. Accordingly, he has a payroll deduction for any consequent personal use of the vehicle.

All other vehicles are stored at the facility when not in use.



TOTALS	<u>511,955.36</u>	<u>70,935.22</u>	<u>64,935.22</u>	<u>(6,000.00)</u>	<u>419,961.12</u>
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Milestone, Inc. - ELMWOOD HEIGHTS # 0024943  
 Schedule of In-Service Training  
 FY 2009

<u>CHECK DATE</u>	<u>CHECK #</u>	<u>AMOUNT</u>	<u>VENDOR</u>	<u>DESCRIPTION</u>
08/19/08	117691	377.00	American Red Cross	CPR & First Aid Training Materials
03/27/09	120287	213.00	American Red Cross	CPR & First Aid Training Materials
06/19/09	122262	318.00	American Red Cross	CPR & First Aid Training Materials
03/20/09	120187	2,222.64	Crisis Prevention Institution	Training Program NCI Participation Workbooks
07/31/08	117091	250.00	Dr. Thomas Lee, MD	Seminar
06/26/09	122417	300.00	Sharon DeBerry	Seminar
	<b>TOTAL</b>	<b><u>\$3,680.64</u></b>		

**ADDENDUM  
A**