



Facility Name & ID Number Milestone Elmwood Heights

# 0024943 Report Period Beginning: 07/01/15 Ending: 06/30/16

**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	30,744	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,744	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	30,005			30,005	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,005			30,005	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 97.60%

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

32 (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: 06/30/16 Fiscal Year: 06/30/16

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

Facility Name & ID Number Milestone Elmwood Heights # 0024943 Report Period Beginning: 07/01/15 Ending: 06/30/16

**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	133,710	19,892	140	153,742		153,742		153,742		1
2	Food Purchase		335,605		335,605		335,605		335,605		2
3	Housekeeping	121,233	139,652	3,847	264,733		264,733		264,733		3
4	Laundry		24,121		24,121		24,121		24,121		4
5	Heat and Other Utilities			166,355	166,355		166,355		166,355		5
6	Maintenance	136,299	184,893	14,207	335,399		335,399		335,399		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	391,242	704,163	184,549	1,279,955		1,279,955		1,279,955		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			27,000	27,000		27,000		27,000		9
10	Nursing and Medical Records	2,763,300	288,610	79,019	3,130,929		3,130,929		3,130,929		10
10a	Therapy										10a
11	Activities		48,729		48,729		48,729		48,729		11
12	Social Services										12
13	CNA Training	192,850			192,850		192,850		192,850		13
14	Program Transportation		25,317	4,157	29,474		29,474		29,474		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,956,150	362,656	110,176	3,428,982		3,428,982		3,428,982		16
	<b>C. General Administration</b>										
17	Administrative	100,756			100,756		100,756		100,756		17
18	Directors Fees										18
19	Professional Services			12,544	12,544		12,544		12,544		19
20	Dues, Fees, Subscriptions & Promotions			25,017	25,017		25,017		25,017		20
21	Clerical & General Office Expenses	149,102	38,341	39,328	226,772		226,772		226,772		21
22	Employee Benefits & Payroll Taxes			896,407	896,407		896,407		896,407		22
23	Inservice Training & Education			1,696	1,696		1,696		1,696		23
24	Travel and Seminar			865	865		865		865		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			61,377	61,377		61,377		61,377		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	249,858	38,341	1,037,234	1,325,434		1,325,434		1,325,434		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,597,250	1,105,160	1,331,959	6,034,371		6,034,371		6,034,371		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:

07/01/15

Ending:

06/30/16

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			177,670	177,670	5,646	183,316	(2,400)	180,916			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			457	457		457		457			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,346	7,346	(3,292)	4,054		4,054			35
36	Other (specify):* Alloc. Maint. Bldg			2,354	2,354	(2,354)						36
37	<b>TOTAL Ownership</b>			187,827	187,827		187,827	(2,400)	185,427			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			334,692	334,692		334,692		334,692			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			334,692	334,692		334,692		334,692			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,597,250	1,105,160	1,854,478	6,556,890		6,556,890	(2,400)	6,554,490			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				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,400)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (2,400)		\$	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			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,400)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	

Milestone Elmwood Heights

ID# 0024943

Report Period Beginning: 07/01/15

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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 A

Facility Name & ID Number Milestone Elmwood Heights

# 0024943

Report Period Beginning:

07/01/15

Ending:

06/30/16

**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):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	0	0	0	0	0	0	0	0	0	0	0	8
<b>B. Health Care and Programs</b>														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
<b>C. General Administration</b>														
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	0	0	0	0	0	0	0	0	0	0	0	0	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Milestone Elmwood Heights # 0024943 Report Period Beginning: 07/01/15 Ending: 06/30/16

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	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>(2,400)</b>	<b>0</b>	<b>(2,400)</b>	<b>37</b>									
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(2,400)</b>	<b>0</b>	<b>(2,400)</b>	<b>45</b>									

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see pages 23 & 24						

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		\$			\$	\$	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 Heights

# 0024943

Report Period Beginning:

07/01/15

Ending:

06/30/16

**VII. RELATED PARTIES**

**A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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

Facility Name & ID Number Milestone Elmwood Heights # 0024943 Report Period Beginning: 07/01/15 Ending: 06/30/16

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Milestone Elmwood Heights

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Ending: 06/30/16

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	\$ 251,502	\$ 251,502	30,660	\$ 133,710	1
2	1	Dietary Supplies	Days	118,990	34	77,201		30,660	19,892	2
3	2	Food Purchase	Days	118,990	34	1,302,467		30,660	335,605	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	183,774	183,774	91,980	121,233	4
5	6	Maintenance Wages	Level of Care/Days	298,570	36	442,431	442,431	91,980	136,299	5
6	21	Clerical Wages	Level of Care/Days	9,360,000	38	678,618	678,618	2,207,520	160,049	6
7	21	Office Supplies	Level of Care/Days	9,360,000	38	162,567		2,207,520	38,341	7
8	21	Telephone	Level of Care/Days	9,360,000	38	166,753		2,207,520	39,328	8
9	22	Fringe Benefits	Wages	16,783,866	42	4,182,410		3,597,251	896,407	9
10	35	Rent-Computer	Level of Care/Days	9,360,000	38	13,959		2,207,520	3,292	10
11	36	Rent Maintenance Building	Level of Care/Days	9,360,000	38	9,981		2,207,520	2,354	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					\$ 7,471,663	\$ 1,556,325		\$ 1,886,510	25

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	Rockford Bank & Trust		X	Line of Credit	N/A	11/30/15	2,500,000		11/30/16	Floating	45									
7	Rockford Bank & Trust		X	Line of Credit-Vehicles	N/A	5/7/13	240,000	23,936	12/7/16	Floating	412									
8											8									
9	<b>TOTAL Facility Related</b>						\$ 2,740,000	\$ 23,936			\$ 457									
<b>B. Non-Facility Related*</b>																				
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$									
15	<b>TOTALS (line 9+line14)</b>						\$ 2,740,000	\$ 23,936			\$ 457									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2015 report.

\$                      **1**

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$                      **2**

3. Under or (over) accrual (line 2 minus line 1).

\$                      **3**

4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)

\$                      **4**

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

**(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**

\$                      **5**

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

**TOTAL REFUND \$                      For                      Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**

\$                      **6**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$                      **7**

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2011	<span style="border-bottom: 1px solid red;">                    </span>	<b>8</b>
2012	<span style="border-bottom: 1px solid red;">                    </span>	<b>9</b>
2013	<span style="border-bottom: 1px solid red;">                    </span>	<b>10</b>
2014	<span style="border-bottom: 1px solid red;">                    </span>	<b>11</b>
2015	<span style="border-bottom: 1px solid red;">                    </span>	<b>12</b>

**FOR BHF USE ONLY**

<b>13</b>	FROM R. E. TAX STATEMENT FOR 2015	\$ <span style="border-bottom: 1px solid red;">                    </span>	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$ <span style="border-bottom: 1px solid red;">                    </span>	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$ <span style="border-bottom: 1px solid red;">                    </span>	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$ <span style="border-bottom: 1px solid red;">                    </span>	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

**2015 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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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:

07/01/15

Ending:

06/30/16

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,570 B. General Construction Type: Exterior Brick Frame Number of Stories

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).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 6 columns: Item, Use, Square Feet, Year Acquired, Cost, and Item ID. Rows include Project, Recreational Land, and TOTALS.

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	84	1980	1979	\$ N/A	\$	30	\$	\$	\$ N/A
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Kitchen Design Plan		1978	550		5			550
10	Intercom System		1978	12,716		10			12,716
11	Door Locking System		1978	14,081		10			14,081
12	Floor Tile		1979	2,870		10			2,870
13	Landscaping		1980	25,659		5			25,659
14	Sign		1980	725		5			725
15	Chain Link Fence		1980	1,377		5			1,377
16	Landscaping		1980	4,071		5			4,071
17	Storage Building		1980	8,471		5			8,471
18	Landscaping		1981	595		5			595
19	Bike Path, Parking Lot, Basketball Court		1982	22,944		15			22,944
20	Parking Lot Repairs		1982	2,216		15			2,216
21	Room Remodeling		1983	4,312		10			4,312
22	Concrete Slab for Shelter		1984	6,751		15			6,751
23	Park Shelter		1984	13,058		15			13,058
24	Driveway Maintenance		1984	2,201		5			2,201
25	Sewer Repair		1984	1,195		20			1,195
26	Landscaping-Trees		1985	1,677		5			1,677
27	Landscaping-Plantscape		1986	4,117		10			4,117
28	Sidewalk Concrete		1988	2,930		20			2,930
29	Sidewalk Improvements		1990	5,490		20			5,490
30	Parking Lot		1990	3,097		15			3,097
31	Parking Lot Repairs		1991	2,430		15			2,430
32	Roof		1992	3,969		20			3,969
33	Outdoor Drinking Fountain		1992	1,998		20			1,998
34	Telephone System		1992	9,600		12			9,600
35	Roof Repairs		1993	6,965		20			6,965
36	Sump Pumps		1993	4,721		10			4,721

\*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:

07/01/15

Ending:

06/30/16

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Furnace	1994	\$ 40,882	\$	20	\$	\$	\$ 40,882	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		20			4,825	40
41	Concrete	1995	5,575	26	20	26		5,575	41
42	Furnace	1995	9,618	68	20	68		9,618	42
43	Roof	1995	1,290	15	20	15		1,290	43
44	Kitchen Sink	1995	1,300	21	20	21		1,300	44
45	Road Stone	1996	1,120		5			1,120	45
46	Air Conditioner	1996	2,476	124	20	124		2,446	46
47	Tile	1996	360		5			360	47
48	Sinks	1997	6,470		15			6,470	48
49	Flood Lights	1997	2,550	128	20	128		2,434	49
50	Air Conditioner	1997	4,055	203	20	203		3,870	50
51	Sidewalk	1997	6,691	335	20	335		6,357	51
52	Black Top Parking Lot	1997	85,125		15			85,125	52
53	Smoke Detectors	1997	16,100		15			16,100	53
54	Roof	1997	7,070	354	20	354		6,629	54
55	Counters	1997	3,706		15			3,706	55
56	Fire Alarm System	1998	3,660	183	20	183		3,370	56
57	Acoustical Ceiling	1998	1,650	83	20	83		1,520	57
58	Sidewalk Repair	1998	5,660	283	20	283		5,093	58
59	Duct Work	1998	1,017	51	20	51		916	59
60	Tile Repair	1998	650		5			650	60
61	Air Conditioner	1998	2,742		15			2,742	61
62	Carpet	1998	1,544		7			1,544	62
63	Driveway Repairs	1998	2,372		15			2,372	63
64	Roof	1998	2,000	100	20	100		1,774	64
65	Dry Valve	1998	1,540		10			1,540	65
66	Roof	1999	5,970	299	20	299		5,225	66
67	Dry Valve	1999	1,815		10			1,815	67
68	Tile	1999	2,600		5			2,600	68
69	Acoustical Ceiling	2000	6,750	338	20	338		5,427	69
70	TOTAL (lines 4 thru 69)		\$ 414,748	\$ 2,611		\$ 2,611	\$	\$ 410,260	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:

07/01/15

Ending:

06/30/16

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 414,748	\$ 2,611		\$ 2,611	\$	\$ 410,260	1
2	Carpet	2000	12,538		5			12,538	2
3	Counter Tops	2000	1,622	36	15	36		1,622	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		10			4,200	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		2,137	10
11	Sump Pump	2003	7,218		10			7,218	11
12	Carpet	2003	8,950		5			8,950	12
13	Air Conditioner	2003	4,705		10			4,705	13
14	Carpet	2003	5,310		5			5,310	14
15	Cabinets	2003	2,409	161	15	161		2,075	15
16	Water Heater	2003	3,694		5			3,694	16
17	Acoustical Ceilings	2004	11,040	552	20	552		6,900	17
18	Carpet	2004	2,094		7			2,094	18
19	Remove ceiling tile & install drywall ceilings	2004	20,380	1,359	15	1,359		16,870	19
20	Carpet	2004	5,058		7			5,058	20
21	Thermostatic control system for heat and air	2004	29,322	1,466	20	1,466		17,960	21
22	Heater	2004	4,660		10			4,660	22
23	Cabinets	2004	8,204	547	15	547		6,609	23
24	Carpet	2004	27,534		7			27,534	24
25	Smoke & Heat Detectors	2004	6,945		10			6,945	25
26	Vinyl Floor	2004	7,242		7			7,242	26
27	Vinyl Floor	2005	5,102		7			5,102	27
28	Cabinets	2005	20,031	1,335	15	1,335		15,067	28
29	Counter Tops	2005	3,097	207	15	207		2,358	29
30	Ceramic Tile	2005	3,377		7			3,377	30
31	Water Pipe Repair	2005	8,955	358	25	358		3,940	31
32	Roof	2005	6,425	321	20	321		3,534	32
33	Replace Sidewalk	2005	10,808	540	20	540		5,854	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 667,552	\$ 9,656		\$ 9,656	\$	\$ 623,248	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:

07/01/15

Ending:

06/30/16

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 667,552	\$ 9,656		\$ 9,656	\$	\$ 623,248	1
2	Furnaces(8)	2006	20,135	1,007	20	1,007		10,413	2
3	Office Remodel	2006	3,870	258	15	258		2,666	3
4	Neo Flooring	2006	9,476		7			9,476	4
5	Cabinets	2006	20,176	1,345	15	1,345		13,787	5
6	Furnace & Air Conditioner	2006	3,295	165	20	165		1,675	6
7	Acoustical Ceiling	2006	6,000	300	20	300		3,050	7
8	Activity Room Remodel	2006	8,980	599	15	599		6,087	8
9	Vinyl Flooring	2006	4,418		7			4,418	9
10	Carpet	2006	22,509		7			22,509	10
11	Furnaces(4)	2006	12,861	643	20	643		6,216	11
12	Concrete Curb&Gutter	2006	14,906	745	20	745		7,169	12
13	Furnace	2007	9,162	458	20	458		4,199	13
14	Water Heater	2007	3,396		5			3,396	14
15	Carpet	2007	18,229		7			18,229	15
16	Vinyl Flooring	2007	6,135		7			6,135	16
17	Gas Water Heater	2007	5,184		5			5,184	17
18	Fire Suppression System	2007	3,325	332	10	332		2,910	18
19	Furnaces(4)	2007	9,514	476	20	476		4,123	19
20	Doors	2007	16,161	1,077	15	1,077		9,247	20
21	Carpet	2008	5,429		7			5,429	21
22	Blacktop Parking Lot	2007	78,292	5,219	15	5,219		43,496	22
23	Fans & Supplies	2008	6,849	342	20	342		2,654	23
24	Service Fire Alarm System	2008	6,848	685	10	685		5,308	24
25	Concrete Ramp	2008	4,136	207	20	207		1,602	25
26	Service Fire Alarm System	2009	3,370	337	10	337		2,443	26
27	Carpet	2009	17,562		5			17,562	27
28	Covered Walkway	2009	850,010	34,000	25	34,000		240,803	28
29	Blacktop Parking Lot	2009	11,142	743	15	743		5,262	29
30	Sidewalks	2009	6,704	335	20	335		2,374	30
31	Double Steel Doors	2009	3,320	221	15	221		1,438	31
32	Carpet	2010	4,878	585	5	585		3,805	32
33	Carpet	2010	13,756		5			13,756	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,877,580	\$ 59,735		\$ 59,735	\$	\$ 1,110,069	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:

07/01/15

Ending:

06/30/16

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,877,580	\$ 59,735		\$ 59,735	\$	\$ 1,110,069	1
2	Vinyl Flooring	2010	7,462		5			7,462	2
3	Carpet	2010	12,481		5			12,481	3
4	Walkway Lighting	2010	46,518	3,101	15	3,101		19,124	4
5	Shingles	2010	4,435	296	15	296		1,774	5
6	Blacktop	2010	8,348	556	15	556		3,200	6
7	Air Conditioner	2011	3,696	185	20	185		939	7
8	Pipe Repair	2011	15,085	754	20	754		3,834	8
9	Sidewalk	2011	8,656	433	20	433		2,164	9
10	Parking lot	2011	182,656	12,177	15	12,177		56,855	10
11	Fire Protection	2011	4,156	415	10	415		1,905	11
12	Water Drainage Lines	2011	3,500	233	15	233		1,050	12
13	Doors&Frames/2 for laundry rooms, 1 for mechanical room (also	2011	5,107	340	15	340		1,532	13
14	Water Heaters (4)	2012	15,526	3,105	5	3,105		13,111	14
15	Pharmacy Remodel/electrical,counter shutter,windows,cabinetry,a	2012	32,834	2,189	15	2,189		9,121	15
16	PVC Conduit for Pole Lighting	2011	4,350	435	10	435		1,740	16
17	Carpet/living area & bedrooms for 63,64,65,66,67,68 as needed	2012	3,980	796	5	796		3,184	17
18	Automatic Door /Training room door	2012	8,933	893	10	893		3,126	18
19	Repair to Heating and Cooling Unit/removed & repiped hot water	2013	3,843	769	5	769		2,626	19
20	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2013	9,380	1,876	5	1,876		6,140	20
21	3 Automatic Doors-Activity Room, Kitchen 65&66	2013	7,637	764	10	764		2,545	21
22	6 automatic Doors/main enterance,back enterance,kitchen entry fo	2013	17,764	1,776	10	1,776		5,181	22
23	Seal black top and restriped parking lot	2013	7,572	757	10	757		2,209	23
24	sidewalk for 63 @ front door area and rear, sidewalk for maintena	2013	3,059	153	20	153		421	24
25	TheraPure Pipeless Height Adjustable Supine Tub	2013	11,844	1,184	10	1,184		3,257	25
26	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2013	5,319	1,064	5	1,064		2,748	26
27	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2014	3,861	772	5	772		1,673	27
28	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2014	6,105	1,221	5	1,221		2,137	28
29	Install Frame and Door in the nursing department bewtween the 2	2014	4,296	430	10	430		680	29
30	Vinyl Flooring&adhesive/kitchens,bathrooms & some bedrooms fo	2014	3,715	743	5	743		929	30
31	Furnish and install two boilers and piping for the Core Building	2015	65,188	2,716	20	2,716		2,716	31
32	Carpet/living area & bedrooms for 63,64,65,66,67,68 as needed	2015	5,380	897	5	897		897	32
33	Allocated Maintenance Building			2,354		2,354			33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,400,266	\$ 103,119		\$ 103,119	\$	\$ 1,286,830	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 241,974	\$ 25,893	\$ 25,893	\$	5-10 yrs	\$ 185,489	71
72	Current Year Purchases	41,282	6,066	6,066		5-10 yrs	6,066	72
73	Fully Depreciated Assets	622,545				5-15 yrs	622,545	73
74	allocated computer		3,292	3,292				74
75	TOTALS	\$ 905,802	\$ 35,251	\$ 35,251	\$		\$ 814,100	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	see page 27			\$ 663,036	\$ 44,946	\$ 42,546	\$ (2,400)		\$ 629,140	76
77										77
78										78
79										79
80	TOTALS			\$ 663,036	\$ 44,946	\$ 42,546	\$ (2,400)		\$ 629,140	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)	\$ 4,071,319	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 183,316	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 180,916	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,400)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,730,070	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 4,053 Description: Copier/Fax/Printer  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			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input 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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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)	17,472	34,990		52,462
4	Clinical Wages (b)	53,503	68,885		122,388
5	In-House Trainer Wages (c)	6,729	11,271		18,000
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 77,704	\$ 115,146	\$	\$ 192,850
10	SUM OF line 9, col. 1 and 2 (e)	\$ 192,850			

**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	88
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	77
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>165</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

# 0024943

Report Period Beginning: 07/01/15

Ending:

06/30/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/16

(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	\$ 3,150	\$ 2,516,155	1
2	Cash-Patient Deposits	76,238	284,125	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	394,274	1,334,415	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance		3,363	6
7	Other Prepaid Expenses	(1,013)	18,925	7
8	Accounts Receivable (owners or related parties)		151,217	8
9	Other(specify): <u>A/R other</u>		46,159	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 472,649	\$ 4,354,359	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable		324,327	11
12	Long-Term Investments			12
13	Land	102,215	1,727,962	13
14	Buildings, at Historical Cost	5,238,477	24,006,097	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,568,837	5,793,738	16
17	Accumulated Depreciation (book methods)	(5,568,281)	(20,190,235)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	81,448	119,073	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(81,448)	(119,073)	20
21	Restricted Funds		1,238,700	21
22	Other Long-Term Assets (specify):		334,528	22
23	Other(specify): <u>CIP &amp; CSV Insurance</u>		454,487	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,341,248	\$ 13,689,604	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,813,897	\$ 18,043,963	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$	\$ 890,782	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	76,238	284,125	28
29	Short-Term Notes Payable		301,992	29
30	Accrued Salaries Payable		1,228,495	30
31	Accrued Taxes Payable (excluding real estate taxes)		112,978	31
32	Accrued Real Estate Taxes(Sch.IX-B)		86	32
33	Accrued Interest Payable		41,858	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Pension, Hlth Plan,etc.</u>		741,139	36
37	<u>Intercompany A/P</u>	6,518,828		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,595,066	\$ 3,601,455	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		141,678	39
40	Mortgage Payable		2,034,324	40
41	Bonds Payable		1,175,000	41
42	Deferred Compensation		458,952	42
<b>Other Long-Term Liabilities(specify):</b>				
43			24,662	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 3,834,616	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,595,066	\$ 7,436,071	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (4,781,168)	\$ 10,607,892	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,813,898	\$ 18,043,963	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>(4,045,451)</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>(4,045,451)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(735,717)</b>	<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>(735,717)</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>(4,781,168)</b>	<b>24</b> *

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

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,557,838	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,557,838	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	246,398	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	9,173	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	3,530	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 259,101	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 Veh and Recycled Metal</u>	4,234	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,234	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,821,173	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,279,955	31
32	Health Care	3,428,982	32
33	General Administration	1,325,434	33
<b>B. Capital Expense</b>			
34	Ownership	187,827	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	334,692	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,556,890	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(735,717)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (735,717)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,941,504	44
45	Private Pay - Net Inpatient Revenue	616,334	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,557,838	49

\* 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 26

\*\*\* 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:

07/01/15

Ending:

06/30/16

**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	214	231	\$ 6,038	\$ 26.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,590	9,766	239,372	24.51	3
4	Licensed Practical Nurses	17,482	19,609	419,436	21.39	4
5	CNAs & Orderlies					5
6	CNA Trainees	20,343	20,343	192,850	9.48	6
7	Licensed Therapist	466	466	30,295	65.01	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	700	835	22,215	26.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,975	10,136	111,495	11.00	15
16	Dishwashers					16
17	Maintenance Workers	7,899	8,932	136,299	15.26	17
18	Housekeepers	10,250	12,087	121,233	10.03	18
19	Laundry					19
20	Administrator	1,368	1,639	66,239	40.41	20
21	Assistant Administrator					21
22	Other Administrative	463	476	34,517	72.51	22
23	Office Manager	4,708	5,456	125,533	23.01	23
24	Clerical	1,815	2,064	23,569	11.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	31,474	35,872	573,598	15.99	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	127,728	139,548	1,494,561	10.71	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	242,475	267,460	\$ 3,597,250 *	\$ 13.45	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	4	\$ 140	1-3	35
36	Medical Director	120	27,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	104	3,422	10-3	38
39	Pharmacist Consultant	72	4,320	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>	541	59,013	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,086	\$ 106,159		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions				
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Linda Thornbloom			\$ 66,239	Workers' Compensation Insurance	\$ 101,351	IDPH License Fee	\$				
Corp. Admin Salaries			34,517	Unemployment Compensation Insurance		Advertising: Employee Recruitment	17,218				
				FICA Taxes	262,390	Health Care Worker Background Check					
				Employee Health Insurance	515,024	(Indicate # of checks performed)					
				Employee Meals		Patient Background Checks					
				Illinois Municipal Retirement Fund (IMRF)*		Dues	2,099				
				Employee Physical Exams	3,416	Fees	5,640				
				Other Employee Benefits	10,143	Books & Periodicals	60				
				Applicant Referral	4,083						
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 100,756	TOTAL (agree to Schedule V, line 22, col.8)			\$ 896,407	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 25,017	
(List each licensed administrator separately.)								Less: Public Relations Expense		( )	
								Non-allowable advertising		( )	
								Yellow page advertising		( )	
B. Administrative - Other											
Description			Amount								
			\$								
TOTAL (agree to Schedule V, line 17, col. 3)			\$								
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount				
RSM McGladrey	Pension Plan	\$ 2,025			\$	Out-of-State Travel	\$				
Various	Computer/Programmer Cslt.	976									
Wipfli LLP	Audit	5,679									
Williams&McCarthy, DuaneMorris	Legal Fees	1,614				In-State Travel					
Peggy Brechon	Administrative Consultant	2,250									
						Seminar Expense	865				
						Entertainment Expense	( )				
TOTAL (agree to Schedule V, line 19, column 3)			\$ 12,544	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)			\$ 865
(For legal fee disclosure, see page 39 of instructions)											

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Milestone Elmwood Heights

# 0024943

Report Period Beginning: 07/01/15

Ending: 06/30/16

**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. \$ 334,692  
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: WIPFLI LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. yes  
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>
Ronald Alden	Treasurer	Pension Accounting	McGladrey & Pullen
George Bass	Director	Insurance	Country Ins. & Financial Group
Thomas Budd	Director	Financial	Rockford Bank & Trust
Randy L. Cooper	Director	Insurance	Williams Manny
Lyla DeVerdi	Director	N/A	
Judd Gastel	Director	N/A	
Peggy Hanson	Secretary	N/A	
Carol Hartline	Chairperson	Legal	Williams & McCarthy
Ben Holmstrom	Vice Chairperson	Construction	William Charles Construction
Jack Kieckhefer	Director	Insurance	Kieckhefer & Nelson
Cyrus Oates	Director	N/A	
Shawn Way	President & CEO	Administrative Services	Rockford Bank & Trust
Audrey Wickstrand	Director	N/A	

**SCHEDULE VII-A: RELATED PARTIES**

<u>MILESTONE, INC.</u>	<u>RESIDENTIAL</u>	<u>CITY</u>	<u>TYPE OF BUSINESS</u>
	<u>BEDS</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.I.L.A. Services
Orchard	8	Rockford	C.I.L.A. Services
Training Center	N/A	Rockford	Developmental Training
Industries	N/A	Loves Park	Developmental Training
RocVale Childrens Home	50	Rockford	Children's Group Home DD
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
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	6	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	7	Rockford	C.I.L.A. Services
Tulip	5	Rockford	C.I.L.A. Services
Packard	5	Rockford	C.I.L.A. Services
Apawamis	4	Rockford	C.I.L.A. Services
Southbridge	5	Rockford	C.I.L.A. Services
South Mulford	8	Rockford	C.I.L.A. Services
Commonwealth	8	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
HUD Project #071-HD160	N/A	Rockford	Housing
HUD Project #071-HD169	N/A	Rockford	Housing
Bingo	N/A	Rockford	Bingo

**RECLASSIFICATION - SCHEDULE V. COLUMN 5**

SCHEDULE  
V

Line #	Title	Amount
30	Depreciation	3,292.00
35	Equipment Rent	(3,292.00)
		<u>0</u>
		-----

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

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30	Depreciation	2,354.00
36	Rent-Maintenance Building	(2,354.00)
		<u>0</u>
		-----

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

**Schedule of Federal Form 990 Reconciliation**

Page 19, Line 41	(\$735,717)
	(\$589,170) Related Organizational Net Income
Federal Form 990 Net Income	<u>(\$1,324,887)</u>

**Asset Listing - VEHICLES**

<i>Description</i>	<i>Date Acquired</i>	<i>Cost</i>	<i>Current Book Depreciation</i>	<i>Life in Years</i>	<i>Straight Line Depreciation</i>	<i>Adjustments</i>	<i>Accumulated Depreciation</i>
04 Ford Crown Victoria	09/30/03	21,529.92	0.00	S/L-3 YE	0.00		21,529.92
04 Ford Truck F150 Van Lift	04/15/04	18,522.72	(A) 0.00	S/L 3 YE	0.00	(2,400.00) (B)	18,522.72
Van Lift	06/17/04	3,735.00	0.00	S/L - 5	0.00		3,735.00
Van Lift	06/17/04	3,735.00	0.00	S/L-5YRS	0.00		3,735.00
04 Ford Freestar	08/25/04	18,347.26	0.00	S/L- 3 Y	0.00		18,347.26
05 Ford Van E150	02/18/05	18,539.58	0.00	S/L-3 YR	0.00		18,539.58
2006 Club Wagon	08/16/05	22,035.60	0.00	S/L-3 YR	0.00		22,035.60
05 Ford Eldorado	10/20/05	47,091.00	0.00	S/L-3 YR	0.00		47,091.00
97 Bus Repairs	11/30/05	10,152.19	0.00	S/L-3 YR	0.00		10,152.19
Bus Repairs	01/10/06	10,458.84	0.00	S/L-3 YR	0.00		10,458.84
06 Ford E350	10/11/06	22,040.40	0.00	S/L-3 YR	0.00		22,040.40
07 Ford Crown Vic	10/26/06	20,611.50	0.00	S/L-3 YR	0.00		20,611.50
06 Ford Eldorado	01/12/07	43,791.00	0.00	S/L-3 YR	0.00		43,791.00
08 Ford Econoline	05/30/08	23,420.00	0.00	S/L-3 YR	0.00		23,420.00
09 Ford Econoline	09/15/08	24,285.00	0.00	S/L-3 YR	0.00		24,285.00
09 Ford Econoline	09/26/08	25,679.00	0.00	S/L-3 YR	0.00		25,679.00
09 Ford Escape	10/06/08	22,741.00	0.00	S/L-3 YE	0.00		22,741.00
10 Ford Lift Van	01/21/10	54,594.00	0.00	S/L-3 YR	0.00		54,594.00
10 Ford Lift Van	01/21/10	54,594.00	0.00	S/L-3 YR	0.00		54,594.00
11 Dodge Caravan	07/08/11	23,419.00	0.00	S/L-3 YR	0.00		23,419.00
12 Ford Taurus	09/16/11	26,852.00	0.00	S/L-3 YR	0.00		26,852.00
12 Ford Truck F-250	08/24/12	23,733.39	659.29	S/L-3 YR	659.29		23,733.39
Plow for Ford Truck	08/23/12	4,338.00	120.50	S/L-3 YR	120.50		4,338.00
04 Ford Truck F250	10/05/12	6,419.00	534.77	S/L-3 YR	534.77		6,419.00
13 Ford E350	07/17/13	52,810.00	17,603.28	S/L-3 YR	17,603.28		52,809.84
14 Ford Taurus	05/13/14	12,456.27	4,152.12	S/L-3 YR	4,152.12		8,996.26
Plow	09/15/14	8,400.00	2,799.96	S/L-3 YR	2,799.96		5,133.26
15 Ford F250	11/03/14	26,003.00	8,667.72	S/L-3 YR	8,667.72		14,446.20
15 Ford Transit Connect	12/31/14	31,225.00	10,408.32	S/L-3 YR	10,408.32		15,612.48
Less: A) Disposals		(18,522.72)					(18,522.72)
B) Gain on Sale of Fixed Assets					(2,400.00)		
C) Insurance Reimbursement					0.00		
<b>TOTALS</b>		<u>663,035.95</u>	<u>44,945.96</u>		<u>42,545.96</u>	<u>(2,400.00)</u>	<u>629,139.72</u>

## Legal Fees

### Williams & McCarthy

<u>Invoice Date</u>	<u>Check #</u>	<u>Amount</u>	<u>Description of Services</u>
07/28/15	192463	210.00	General Employment Matters
11/17/15	193440	240.00	General Employment Matters
11/20/15	193440	150.00	General Employment Matters
01/22/16	194128	90.00	General Employment Matters
01/22/16	194128	150.00	General Employment Matters
03/23/16	194616	60.00	General Employment Matters
06/23/16	195396	60.00	General Employment Matters

### Duane Morris, LLP

<u>Invoice Date</u>	<u>Check #</u>	<u>Amount</u>	<u>Description of Services</u>
11/17/15	193423	340.00	Regulatory & Compliance