

		FOR BHF USE					

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0027326

Facility Name: Milestone - Searles

Address: 3310 Searles Avenue Rockford 61101
Number City Zip Code

County: Winnebago

Telephone Number: (815) 965-3390 Fax # (815) 966-0160

HFS ID Number:

Date of Initial License for Current Owners: 11/18/1982

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust

IRS Exemption Code 501 (c) 3

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/10 to 06/30/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

Facility Name & ID Number Milestone - Searles

0027326 Report Period Beginning: 07/01/10 Ending: 06/30/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	Skilled (SNF)			1
2	Skilled Pediatric (SNF/PED)			2
3	Intermediate (ICF)			3
4	Intermediate/DD			4
5	Sheltered Care (SC)			5
6	12ICF/DD 16 or Less	12	4,380	6
7	12TOTALS	12	4,380	7

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	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				11
12	SC				12
13	DD 16 OR LESS	4,322		4,322	13
14	TOTALS	4,322		4,322	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.68%

D. How many bed-hold days during this year were paid by the Department? 39 (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 X

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

I. On what date did you start providing long term care at this location? Date started 11/18/1982

J. Was the facility purchased or leased after January 1, 1978? YES X Date 02/11/82 NO

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

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL X MODIFIED CASH* CASH*

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

Tax Year: 06/30/11 Fiscal Year: 06/30/11 * All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Milestone - Searles # 0027326 Report Period Beginning: 07/01/10 Ending: 06/30/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	18,170	2,452	800	21,422		21,422		21,422			1
2	Food Purchase		39,313		39,313		39,313		39,313			2
3	Housekeeping	11,325			11,325		11,325		11,325			3
4	Laundry		92		92		92		92			4
5	Heat and Other Utilities			13,545	13,545		13,545		13,545			5
6	Maintenance	15,860	7,310	4,000	27,170		27,170		27,170			6
7	Other (specify):* Maint. Fee			24,695	24,695		24,695	(24,695)				7
8	TOTAL General Services	45,355	49,167	43,040	137,562		137,562	(24,695)	112,867			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	266,616	2,125	1,752	270,493		270,493		270,493			10
10a	Therapy											10a
11	Activities		1,772		1,772		1,772		1,772			11
12	Social Services	14,074			14,074		14,074		14,074			12
13	CNA Training											13
14	Program Transportation		2,026	1,251	3,277		3,277		3,277			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	280,690	5,923	3,003	289,616		289,616		289,616			16
	C. General Administration											
17	Administrative	11,839			11,839		11,839		11,839			17
18	Directors Fees											18
19	Professional Services			32,532	32,532		32,532	(1,728)	30,804			19
20	Dues, Fees, Subscriptions & Promotions											20
21	Clerical & General Office Expenses	24,486	4,451	3,739	32,676		32,676		32,676			21
22	Employee Benefits & Payroll Taxes			79,887	79,887		79,887		79,887			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,859	1,859		1,859		1,859			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			4,641	4,641		4,641		4,641			26
27	Other (specify):* Management Fee			5,376	5,376		5,376	(5,376)				27
28	TOTAL General Administration	36,325	4,451	128,034	168,810		168,810	(7,104)	161,706			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	362,370	59,541	174,077	595,988		595,988	(31,799)	564,189			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	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			18,547	18,547	700	19,247		19,247			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,423	19,423		19,423	(288)	19,135			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			31,120	31,120		31,120	(31,120)				34
35	Rent-Equipment & Vehicles			2,842	2,842	(327)	2,515		2,515			35
36	Other (specify):* Alloc. Maint. Bldg			373	373	(373)						36
37	TOTAL Ownership			72,305	72,305		72,305	(31,408)	40,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			27,720	27,720		27,720		27,720			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			27,720	27,720		27,720		27,720			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	362,370	59,541	274,102	696,013		696,013	(63,207)	632,806			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(31,120)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(288)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see page 5A	(31,799)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (63,207)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (63,207)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Management Fee	\$ (5,376)	27	1
2	Maintenance Fee	(24,695)	7	2
3	Bookkeeping/Computer Fee	(1,728)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(31,799)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Milestone - Searles # 0027326 Report Period Beginning: 07/01/10 Ending: 06/30/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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):*	(24,695)	0	0	0	0	0	0	0	0	0	0	(24,695)	7
8	TOTAL General Services	(24,695)	0	0	0	0	0	0	0	0	0	0	(24,695)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,728)	0	0	0	0	0	0	0	0	0	0	(1,728)	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):*	(5,376)	0	0	0	0	0	0	0	0	0	0	(5,376)	27
28	TOTAL General Administration	(7,104)	0	0	0	0	0	0	0	0	0	0	(7,104)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(31,799)	0	0	0	0	0	0	0	0	0	0	(31,799)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Milestone - Searles # 0027326 Report Period Beginning: 07/01/10 Ending: 06/30/11

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(288)	0	0	0	0	0	0	0	0	0	0	(288)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(31,120)	0	0	0	0	0	0	0	0	0	0	(31,120)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(31,408)	0	0	0	0	0	0	0	0	0	0	(31,408)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(63,207)	0	0	0	0	0	0	0	0	0	0	(63,207)	45

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 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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		see page 28	\$			\$	\$	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.

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO []

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	\$ 239,234	\$ 239,234	4,380	\$ 18,170	1
2	1	Dietary Supplies	Days	117,530	33	65,788	0	4,380	2,452	2
3	2	Food Purchase	Days	117,530	33	1,054,907	0	4,380	39,313	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	180,260		8,760	11,325	4
5	6	Maintenance Wages	Level of Care/Days	288,482	34	522,306	522,306	8,760	15,860	5
6	21	Clerical Wages	Level of Care/Days	9,117,888	36	565,791	565,791	315,360	19,569	6
7	21	Office Supplies	Level of Care/Days	9,117,888	36	128,689	0	315,360	4,451	7
8	21	Telephone	Level of Care/Days	9,117,888	36	108,104	0	315,360	3,739	8
9	22	Fringe Benefits	Wages	16,067,340	41	3,542,164	3,542,164	362,370	79,887	9
10	35	Rent-Computer	Level of Care/Days	9,117,888	36	9,445	0	315,360	327	10
11	36	Rent Maintenance Building	Level of Care/Days	9,117,888	36	10,778	0	315,360	373	11
12										12
13										13
14		See also 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					\$ 6,427,466	\$ 4,869,495		\$ 195,466	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	U.S. Dept. of HUD		X	Mortgage	\$2,520.00	07/06/81	\$ 343,700	\$ 213,620	04/01/22	8.5000	\$ 18,614	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Rockford Bank & Trust		X	Line of Credit	N/A	11/30/10	2,500,000		11/30/11	7.2500	809	6
7												7
8												8
9	TOTAL Facility Related				\$2,520.00		\$ 2,843,700	\$ 213,620			\$ 19,423	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 2,843,700	\$ 213,620			\$ 19,423	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.)

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 2010 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 2011 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:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

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

FACILITY NAME	Milestone - Searles	COUNTY	Winnebago
---------------	---------------------	--------	-----------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u>
<u>ex Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Nursing Home</u>

B. Real Estate Tax Cost Allocations

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,800

B. General Construction Type: Exterior BrickFrame

Number of Stories One

C. Does the Operating Entity?

X(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

X(a) Own the Equipment

X(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

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

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

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

YES

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Project	129,294	1982	\$ 17,914	1
2					2
3	TOTALS	129,294		\$ 17,914	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	12		1982	1981	\$ 326,947	\$ 3,114	50	\$ 3,114		\$ 264,672	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof			1993	5,025	252	20	252		4,481	9
10	Plumbing			1997	4,560	304	15	304		4,205	10
11	Smoke Detectors			1997	2,850	190	15	190		2,628	11
12	Blacktop			1997	5,188	346	15	346		4,438	12
13	Floor Repair			1998	625	25	25	25		320	13
14	Carpet			1998	4,063		7			4,063	14
15	Window Treatments			1998	1,291		10			1,291	15
16	Water Heater			2002	2,789	279	10	279		2,651	16
17	Patio Door			2003	2,845	190	15	190		1,533	17
18	Carpet			2004	3,101	221	7	221		3,101	18
19	Condenser			2004	3,105	311	10	311		2,225	19
20	Replacement of doors & windows			2003	30,504	1,220	25	1,220		9,355	20
21	Deck & Railing			2004	9,137	457	20	457		3,236	21
22	Cabinets			2006	4,579	305	15	305		1,628	22
23	Kitchen Remodel			2006	3,170	211	15	211		1,127	23
24	Garage			2006	19,654	786	25	786		3,931	24
25	Air Conditioner			2008	4,920	246	20	246		820	25
26	Blacktop			2011	12,631	70	15	70		70	26
27	Allocated Maintenance Building					373		373			27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 446,984	\$ 8,900		\$ 8,900	\$	\$ 315,775	70

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

XI. OWNERSHIP COSTS (continued)								
C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,990	\$ 110	\$ 110		15 yrs.	\$ 3,990	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	39,433				5-10 yrs.	39,433	73
74	Central Office Computer		327	327				74
75	TOTALS	\$ 43,423	\$ 437	\$ 437	\$		\$ 43,423	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	Patient Care	2008 Ford Van	2007	\$ 24,811	\$ 2,757	\$ 2,757		3	\$ 24,811	76
77	Patient Care	Vehicle Chair Lift	2008	6,008	1,001	1,001		3	6,008	77
78	Patient Care	2011 Ford Van	2010	24,610	6,152	6,152		3	6,152	78
79										79
80	TOTALS			\$ 55,429	\$ 9,910	\$ 9,910	\$		\$ 36,971	80

E. Summary of Care-Related Assets				1	2
		Reference			Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 563,750
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 19,247
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 19,247
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 396,169

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- ☐ YES
- ☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized
- by the length of the lease
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO

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

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
- Beginning
- Ending
11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending
- Annual Rent
12. /2012 \$
13. /2013 \$
14. /2014 \$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 83,577	\$ 2,148,340	1
2	Cash-Patient Deposits	7,256	234,847	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	72,785	2,925,970	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		18,139	6
7	Other Prepaid Expenses		47,766	7
8	Accounts Receivable (owners or related parties)		156,187	8
9	Other(specify): A/R other	128	23,236	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 163,746	\$ 5,554,485	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		22,489	11
12	Long-Term Investments			12
13	Land	17,914	1,566,296	13
14	Buildings, at Historical Cost	446,984	19,867,267	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	98,852	5,159,265	16
17	Accumulated Depreciation (book methods)	(396,169)	(15,860,676)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		110,273	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(110,273)	20
21	Restricted Funds		1,235,000	21
22	Other Long-Term Assets (spe Escrow & loan fees		337,214	22
23	Other(specify): CIP & CSV Insurance		245,802	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 167,581	\$ 12,572,657	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 331,327	\$ 18,127,142	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 697	\$ 548,722	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,256	234,847	28
29	Short-Term Notes Payable		185,000	29
30	Accrued Salaries Payable		945,807	30
31	Accrued Taxes Payable (excluding real estate taxes)		77,803	31
32	Accrued Real Estate Taxes(Sch.IX-B)		85	32
33	Accrued Interest Payable	1,513	66,137	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Pension,Hlth Plan, etc.	1,824	604,942	36
37	Intercompany Account Payable	465,758		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 477,048	\$ 2,663,343	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	213,620	2,673,455	40
41	Bonds Payable		2,305,000	41
42	Deferred Compensation		273,994	42
	Other Long-Term Liabilities(specify):			
43	Deferred Revenue-HUD	1,794	1,794	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 215,414	\$ 5,254,243	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 692,462	\$ 7,917,586	46
47	TOTAL EQUITY(page 18, line 24)	\$ (361,135)	\$ 10,209,556	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 331,327	\$ 18,127,142	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (340,296)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (340,296)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(20,839)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (20,839)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (361,135)	24 *

* 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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 541,987	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 541,987	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	69,714	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	31,386	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 101,100	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	288	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 288	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management & Maintenance Fee	30,071	28
28a	Bookkeeping/Computer Fee	1,728	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 31,799	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 675,174	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	137,562	31
32	Health Care	289,616	32
33	General Administration	168,810	33
	B. Capital Expense		
34	Ownership	72,305	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	27,720	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 696,013	40
41	Income before Income Taxes (line 30 minus line 40)**	(20,839)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (20,839)	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 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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	669	791	18,429	23.30	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	681	783	14,074	17.97	11
12	Dietician					12
13	Food Service Supervisor	96	118	3,051	25.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,315	1,457	15,118	10.38	15
16	Dishwashers					16
17	Maintenance Workers	911	1,037	15,860	15.29	17
18	Housekeepers	1,005	1,149	11,325	9.86	18
19	Laundry					19
20	Administrator	165	191	7,318	38.31	20
21	Assistant Administrator					21
22	Other Administrative	60	62	4,521	72.92	22
23	Office Manager	598	695	15,048	21.65	23
24	Clerical	717	814	9,438	11.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,024	2,300	39,768	17.29	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	17,642	19,239	208,420	10.83	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	25,883	28,636	\$ 362,370 *	\$ 12.65	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	20	\$ 800	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	35	1,752	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	55	\$ 2,552		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			
Name	Function	Ownership %	Amount
William Grahn	Administrative		\$ 7,318
Corp. Admin. Salaries	Administrative		4,521
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 11,839
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			
Vendor/Payee	Type		Amount
Wipfli LLP	Audit		\$ 3,223
Various	Computer/Programmer		2,123
Duane Morris LLP, Michigan Peer	Legal Fees		26,746
RSM McGladrey	Pension Plan		440
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 32,532
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 7,792
Unemployment Compensation Insurance			1,801
FICA Taxes			26,193
Employee Health Insurance			36,454
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Pension			5,638
Employee Physical Exams			287
Applicant Referral Expense			101
Other Employee Benefits			1,621
TOTAL (agree to Schedule V, line 22, col.8)			\$ 79,887
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks			
Less: Public Relations Expense		(	)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)			\$
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			1,859
see page 26			
Entertainment Expense		(	)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,859

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? n/a
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ 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. \$ 27,720
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 benefit: 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?
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? _____
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) 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? yes
Attach invoices and a summary of services for all architect and appraisal fees

SCHEDULE VII-A: BOARD MEMBER LISTING

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

SCHEDULE VII-A: RELATED PARTIES

<u>MILESTONE, INC.</u>	RESIDENTIAL <u>BEDS</u>	<u>CITY</u>	TYPE OF <u>BUSINESS</u>
Central Office	N/A	Rockford	Central Office
Elmwood Heights	84	Rockford	ICF/MR-SLC
Elmwood East	12	Rockford	ICF/DD<16 & Fewer
Searles	12	Rockford	ICF/DD<16 & Fewer
Sun Valley	8	Rockford	ICF/DD<16 & Fewer
Applewood	8	Loves Park	C.R.A. - Waiver/C.I.L.A. Services
Orchard	8	Rockford	C.R.A. - Waiver/C.I.L.A. Services
Training Center	N/A	Rockford	Developmental Training
Industries	N/A	Loves Park	Developmental Training
RocVale Childrens Home	50	Rockford	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
Oleson (closed 9/22/10)	9	Rockford	C.I.L.A. Services
South Mulford (opened 9/22/1	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	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
Southbridge	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
HUD Project #071-HD160	N/A	Rockford	Housing
Bingo	N/A	Rockford	Bingo

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#/ Confirmation #</u>	<u>COST</u>
1. Erika Sheely	RSD	July 27-30, 2011	Rockford, IL	Four-Day Instructor Certification Program	Crisis Prevention Intervention	W5631	1,529.00
2. Lisa Salazar	Social Worker	Sept. 22, 2010	Schaumburg, IL	Palliative Care: Comfort, Communication, Choices, Control	PESI Healthcare	W8044	179.00
3. Ericka Sheely	RSD	Aug. 10-13, 2010	New Orleans, LA	15th Annual Conference	National Association of QDDP's	127348	<u>151.28</u>
						Total	<u><u>1,859.28</u></u>

Schedule of Federal Form 990 Reconciliation

Page 19, Line 41	(\$20,839)
Related Organizations Net Income	322,187
Federal Form 990 Net Income	<u><u>\$301,348</u></u>

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

<u>Page</u>	<u>Line</u>	<u>Column</u>	<u>Description</u>	<u>DR / (CR)</u>
3	7	7	Maintenance Fee Expense	(24,695)
3	27	7	Management Fee Expense	(5,376)
3	19	7	Bookkeeping/Computer Fee	(1,728)
19	29	1	Management/Maintenance Fee Revenue	31,799
4	34	7	Rent Expense - Facility	(31,120)
19	16	1	Rent Revenue - Facility	31,120

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

<u>Page</u>	<u>Line</u>	<u>Column</u>	<u>Description</u>	<u>DR / (CR)</u>
4	32	7	Interest Expense	(288)
19	25	1	Interest Income	288

RECLASSIFICATION - SCHEDULE V. COLUMN 5

SCHEDULE		
V		
<u>Line #</u>	<u>Title</u>	<u>Amount</u>
30	Depreciation	327.00
35	Equipment Rent	(327.00)
		<u>0</u>

To reclassify rental of Computer from Milestone, Inc. Central Office.		
30	Depreciation	373.00
36	Rent-Maintenance Building	(373.00)
		<u>0</u>

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