

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: 0024943

Facility Name: Milestone-Elmwood Heights

Address: 2662 Elmwood Road Rockford 61103
Number City Zip Code

County: Winnebago

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

HFS ID Number:

Date of Initial License for Current Owners: 09/01/79

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 W. Lippitt Telephone Number: (815) 654-6100
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 07/01/11 to 06/30/12 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
(Title) Senior Vice President & C.F.O.

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

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

Facility Name & ID Number

Milestone-Elmwood Heights

#

0024943

Report Period Beginning:

07/01/11

Ending:

06/30/12

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		30,744	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS		30,744	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	30,370			30,370	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,370			30,370	14

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

98.78%

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

324

(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

09/04/79

J. Was the facility purchased or leased after January 1, 1978?

YES

Date

NO

X

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:

06/30/12

Fiscal Year:

06/30/12

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

	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	128,228	18,822	2,392	149,442		149,442		149,442			1
2	Food Purchase		295,730		295,730		295,730		295,730			2
3	Housekeeping	110,363	185,325	20,447	316,135		316,135		316,135			3
4	Laundry		37,343		37,343		37,343		37,343			4
5	Heat and Other Utilities			152,010	152,010		152,010		152,010			5
6	Maintenance	162,727	238,460	23,758	424,945		424,945		424,945			6
7	Other (specify):*											7
8	TOTAL General Services	401,318	775,680	198,607	1,375,605		1,375,605		1,375,605			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	2,418,088	287,319	67,384	2,772,791		2,772,791		2,772,791			10
10a	Therapy											10a
11	Activities		35,744	150	35,894		35,894		35,894			11
12	Social Services											12
13	CNA Training	155,124			155,124		155,124		155,124			13
14	Program Transportation		46,335	4,665	51,000		51,000		51,000			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,573,212	369,398	96,199	3,038,809		3,038,809		3,038,809			16
	C. General Administration											
17	Administrative	95,079			95,079		95,079		95,079			17
18	Directors Fees											18
19	Professional Services			19,354	19,354		19,354		19,354			19
20	Dues, Fees, Subscriptions & Promotions			10,939	10,939		10,939		10,939			20
21	Clerical & General Office Expenses	131,204	34,881	29,477	195,562		195,562		195,562			21
22	Employee Benefits & Payroll Taxes			714,698	714,698		714,698		714,698			22
23	Inservice Training & Education			2,662	2,662		2,662		2,662			23
24	Travel and Seminar			6,587	6,587		6,587		6,587			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,219	58,219		58,219		58,219			26
27	Other (specify):*											27
28	TOTAL General Administration	226,283	34,881	841,936	1,103,100		1,103,100		1,103,100			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,200,813	1,179,959	1,136,742	5,517,514		5,517,514		5,517,514			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			214,403	214,403	5,634	220,037	(2,324)	217,713			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,283	4,283		4,283		4,283			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,175	15,175	(3,517)	11,658		11,658			35
36	Other (specify):* Alloc. Maint. Bldg			2,117	2,117	(2,117)						36
37	TOTAL Ownership			235,978	235,978		235,978	(2,324)	233,654			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			329,572	329,572		329,572		329,572			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			329,572	329,572		329,572		329,572			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,200,813	1,179,959	1,702,292	6,083,064		6,083,064	(2,324)	6,080,740			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	(2,324)	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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,324)		\$	30

BHF USE ONLY							
48		49		50		51	52

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))	\$ (2,324)		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

Milestone-Elmwood Heights

	ID#	0024943
Report Period Beginning:		07/01/11
Ending:		06/30/12

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	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/11 Ending: 06/30/12

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):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	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	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	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (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: 07/01/11 Ending: 06/30/12

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(2,324)	0	0	0	0	0	0	0	0	0	0	(2,324)	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	TOTAL Ownership	(2,324)	0	0	0	0	0	0	0	0	0	0	(2,324)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(2,324)	0	0	0	0	0	0	0	0	0	0	(2,324)	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 page 24 & 25						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

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

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

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.

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	\$ 241,191	\$ 241,191	30,660	\$ 128,228	1
2	1	Dietary Supplies	Days	117,530	33	72,151		30,660	18,822	2
3	2	Food Purchase	Days	117,530	33	1,133,632		30,660	295,730	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	167,296	167,296	91,980	110,363	4
5	6	Maintenance Wages	Level of Care/Days	289,810	34	512,718	512,718	91,980	162,727	5
6	21	Clerical Wages	Level of Care/Days	9,149,760	36	447,755	447,755	2,207,520	108,028	6
7	21	Office Supplies	Level of Care/Days	9,149,760	36	144,574		2,207,520	34,881	7
8	21	Telephone	Level of Care/Days	9,149,760	36	122,179		2,207,520	29,478	8
9	22	Fringe Benefits	Wages	16,185,858	41	365,673		3,200,813	72,313	9
10	35	Rent-Computer	Level of Care/Days	9,149,760	36	14,575		2,207,520	3,516	10
11	36	Rent Maintenance Building	Level of Care/Days	9,149,760	36	8,774		2,207,520	2,117	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					\$ 3,230,518	\$ 1,368,960		\$ 966,203	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							\$		\$			\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	Rockford Bank & Trust		X	Line of Credit	N/A	11/30/11		2,500,000		11/30/12		7.2500	4,283	6
7														7
8														8
9	TOTAL Facility Related						\$	2,500,000	\$			\$	4,283	9
	B. Non-Facility Related*													
10														10
11														11
12														12
13														13
14	TOTAL Non-Facility Related						\$		\$			\$		14
15	TOTALS (line 9+line14)						\$	2,500,000	\$			\$	4,283	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.)

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Milestone-Elmwood Heights</u>	COUNTY	<u>Winnebago</u>
---------------	----------------------------------	--------	------------------

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 2011 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 2011.

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

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,570

B. General Construction Type: Exterior BrickFrame Cement Block

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

(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

XNO

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Project	261,356	1978	\$ 102,215	1
2	recreational land	304,947	1978		2
3	TOTALS	566,303		\$ 102,215	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	84		1980	1979	\$ N/A	\$	30	\$	\$	n/a	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Kitchen Design Plan			1978	550		5			550	9
10	Intercom System			1978	12,716		10			12,716	10
11	Door Locking System			1978	14,081		10			14,081	11
12	Floor Tile			1979	2,870		10			2,870	12
13	Landscaping			1980	25,659		5			25,659	13
14	Sign			1980	725		5			725	14
15	Chain Link Fence			1980	1,377		5			1,377	15
16	Landscaping			1980	4,071		5			4,071	16
17	Storage Building			1980	8,471		5			8,471	17
18	Landscaping			1981	595		5			595	18
19	Bike Path, Parking Lot, Basketball Court			1982	22,944		15			22,944	19
20	Parking Lot Repairs			1982	2,216		15			2,216	20
21	Room Remodeling			1983	4,312		10			4,312	21
22	Concrete Slab for Shelter			1984	6,751		15			6,751	22
23	Park Shelter			1984	13,058		15			13,058	23
24	Driveway Maintenance			1984	2,201		5			2,201	24
25	Sewer Repair			1984	1,195		20			1,195	25
26	Landscaping-Trees			1985	1,677		5			1,677	26
27	Landscaping-Plantscape			1986	4,117		10			4,117	27
28	Sidewalk Concrete			1988	2,930		20			2,930	28
29	Sidewalk Improvements			1990	5,490		20			5,490	29
30	Parking Lot			1990	3,097		15			3,097	30
31	Parking Lot Repairs			1991	2,430		15			2,430	31
32	Roof			1992	3,969	175	20	175		3,969	32
33	Outdoor Drinking Fountain			1992	1,998	90	20	90		1,998	33
34	Telephone System			1992	9,600		12			9,600	34
35	Roof Repairs			1993	6,965	348	20	348		6,530	35
36	Sump Pumps			1993	4,721		10			4,721	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Furnace	1994	\$ 40,882	\$ 2,044	20	\$ 2,044	\$	\$ 36,122	37
38	Telephones	1994	3,111		12			3,111	38
39	Air Handler	1995	1,668		7			1,668	39
40	Above Ground Tank	1995	4,825	241	20	241		4,123	40
41	Concrete	1995	5,575	279	20	279		4,712	41
42	Furnace	1995	9,618	481	20	481		8,108	42
43	Roof	1995	1,290	65	20	65		1,081	43
44	Kitchen Sink	1995	1,300	65	20	65		1,084	44
45	Road Stone	1996	1,120		5			1,120	45
46	Air Conditioner	1996	2,476	124	20	124		1,951	46
47	Tile	1996	360		5			360	47
48	Sinks	1997	6,470	324	15	324		6,470	48
49	Flood Lights	1997	2,550	128	20	128		1,924	49
50	Air Conditioner	1997	4,055	203	20	203		3,059	50
51	Sidewalk	1997	6,691	335	20	335		5,018	51
52	Black Top Parking Lot	1997	85,125	5,675	15	5,675		85,125	52
53	Smoke Detectors	1997	16,100	1,073	15	1,073		15,920	53
54	Roof	1997	7,070	353	20	353		5,214	54
55	Counters	1997	3,706	247	15	247		3,603	55
56	Fire Alarm System	1998	3,660	183	20	183		2,638	56
57	Acoustical Ceiling	1998	1,650	83	20	83		1,190	57
58	Sidewalk Repair	1998	5,660	283	20	283		3,962	58
59	Duct Work	1998	1,017	51	20	51		712	59
60	Tile Repair	1998	650		5			650	60
61	Air Conditioner	1998	2,742	183	15	183		2,559	61
62	Carpet	1998	1,544		7			1,544	62
63	Driveway Repairs	1998	2,372	158	15	158		2,188	63
64	Roof	1998	2,000	100	20	100		1,375	64
65	Dry Valve	1998	1,540		10			1,540	65
66	Roof	1999	5,970	299	20	299		4,031	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		4,076	69
70	TOTAL (lines 4 thru 69)		\$ 414,748	\$ 13,928		\$ 13,928	\$	\$ 391,004	70

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

Facility Name & ID Number Milestone-Elmwood Heights

0024943

Report Period Beginning:

07/01/11

Ending:

06/30/12

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 414,748	\$ 13,928		\$ 13,928	\$	\$ 391,004	1
2	Carpet	2000	12,538		5			12,538	2
3	Counter Tops	2000	1,622	108	15	108		1,261	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	245	10	245		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		1,484	10
11	Sump Pump	2003	7,218	722	10	722		6,556	11
12	Carpet	2003	8,950		5			8,950	12
13	Air Conditioner	2003	4,705	470	10	470		4,235	13
14	Carpet	2003	5,310		5			5,310	14
15	Cabinets	2003	2,409	160	15	160		1,433	15
16	Water Heater	2003	3,694		5			3,694	16
17	Acoustical Ceilings	2004	11,040	552	15	552		4,692	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		11,435	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		12,096	21
22	Heater	2004	4,660	466	10	466		3,805	22
23	Cabinets	2004	8,204	545	15	545		4,421	23
24	Carpet	2004	27,534	894	7	894		27,534	24
25	Smoke & Heat Detectors	2004	6,945	695	10	695		5,441	25
26	Vinyl Floor	2004	7,242	259	7	259		7,242	26
27	Vinyl Floor	2005	5,102	365	7	365		5,102	27
28	Cabinets	2005	20,031	1,335	15	1,335		9,725	28
29	Counter Tops	2005	3,097	207	15	207		1,532	29
30	Ceramic Tile	2005	3,377	362	7	362		3,377	30
31	Water Pipe Repair	2005	8,955	358	25	358		2,507	31
32	Roof	2005	6,425	321	20	321		2,249	32
33	Replace Sidewalk	2005	10,808	540	20	540		3,692	33
34	TOTAL (lines 1 thru 33)		\$ 667,552	\$ 25,520		\$ 25,520	\$	\$ 572,102	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 667,552	\$ 25,520		\$ 25,520	\$	\$ 572,102	1
2	Furnaces(8)	2006	20,135	1,007	20	1,007		6,386	2
3	Office Remodel	2006	3,870	258	15	258		1,634	3
4	Neo Flooring	2006	9,476	1,354	7	1,354		8,573	4
5	Cabinets	2006	20,176	1,345	15	1,345		8,407	5
6	Furnace & Air Conditioner	2006	3,295	165	20	165		1,016	6
7	Acoustical Ceiling	2006	6,000	300	20	300		1,850	7
8	Activity Room Remodel	2006	8,980	599	15	599		3,692	8
9	Vinyl Flooring	2006	4,418	631	7	631		3,892	9
10	Carpet	2006	22,509	3,216	7	3,216		18,322	10
11	Furnaces(4)	2006	12,861	643	20	643		3,644	11
12	Concrete Curb&Gutter	2006	14,906	745	20	745		4,188	12
13	Furnace	2007	9,162	458	20	458		2,367	13
14	Water Heater	2007	3,396	623	5	623		3,396	14
15	Carpet	2007	18,229	2,604	7	2,604		12,706	15
16	Vinyl Flooring	2007	6,135	876	7	876		4,236	16
17	Gas Water Heater	2007	5,184	1,037	5	1,037		5,012	17
18	Fire Suppresion System	2007	3,325	333	10	333		1,580	18
19	Furnaces(4)	2007	9,514	476	20	476		2,220	19
20	Doors	2007	16,161	1,077	15	1,077		4,938	20
21	Carpet	2008	5,429	776	7	776		3,425	21
22	Blacktop Parking Lot	2007	78,292	5,220	15	5,220		22,618	22
23	Fans & Supplies	2008	6,849	343	20	343		1,284	23
24	Service Fire Alarm System	2008	6,848	685	10	685		2,568	24
25	Concrete Ramp	2008	4,136	207	20	207		775	25
26	Service Fire Alarm System	2009	3,370	337	10	337		1,095	26
27	Carpet	2009	17,562	3,512	5	3,512		11,161	27
28	Covered Walkway	2009	850,010	34,000	25	34,000		104,801	28
29	Blacktop Parking Lot	2009	11,142	743	15	743		2,290	29
30	Sidewalks	2009	6,704	335	20	335		1,034	30
31	Double Steel Doors	2009	3,320	221	15	221		553	31
32	Carpet	2010	4,878	585	5	585		1,463	32
33	Carpet	2010	13,756	2,751	5	2,751		6,649	33
34	TOTAL (lines 1 thru 33)		\$ 1,877,580	\$ 92,982		\$ 92,982	\$	\$ 829,877	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,877,580	\$ 92,982		\$ 92,982	\$	\$ 829,877	1
2	Vinyl Flooring	2010	7,462	1,492	5	1,492		3,358	2
3	Carpet	2010	12,481	2,496	5	2,496		5,617	3
4	Walkway Lighting	2010	46,518	3,101	15	3,101		6,719	4
5	Shingles	2010	4,435	296	15	296		591	5
6	Blacktop	2010	8,348	557	15	557		974	6
7	Air Conditioner	2011	3,696	185	20	185		200	7
8	Pipe Repair	2011	15,085	754	20	754		817	8
9	Sidewalk	2011	8,656	433	20	433		433	9
10	Parking lot	2011	182,656	8,147	15	8,147		8,147	10
11	Fire Protection	2011	4,156	242	10	242		242	11
12	Water Drainage Lines	2011	3,500	117	15	117		117	12
13	Doors&Frames/2 for laundry rooms, 1 for mechanical room (also i	2011	5,107	170	15	170		170	13
14	Water Heaters (4)	2012	15,526	691	5	691		691	14
15	Pharmacy Remodel/electrical,counter shutter,windows,cabinetry,a	2012	32,834	365	15	365		365	15
16	PVC Conduit for Pole Lighting	2011	4,350		10				16
17	Capital Grant Building			324			(324)		17
18	Allocated Maintenance Building			2,117		2,117			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	TOTAL (lines 1 thru 33)		\$ 2,232,390	\$ 114,469		\$ 114,145	\$ (324)	\$ 858,318	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	\$ 290,231	\$ 35,435	\$ 35,435	\$	5-15 yrs	\$ 166,700	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	521,766				5-15 yrs	521,766	73
74	Allocated Computer System		3,517	3,517				74
75	TOTALS	\$ 811,997	\$ 38,952	\$ 38,952	\$		\$ 688,466	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 30			\$ 585,890	\$ 66,616	\$ 64,616	\$ (2,000)		\$ 526,746	76
77										77
78										78
79										79
80	TOTALS			\$ 585,890	\$ 66,616	\$ 64,616	\$ (2,000)		\$ 526,746	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)	\$ 3,732,492	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 220,037	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 217,713	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,324)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,073,530	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

**

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

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

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$11,658
- Description: copier
- (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.	/2013	\$
13.	/2014	\$
14.	/2015	\$

* 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.

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

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	15,299	32,434		47,733
4	Clinical Wages (b)	24,524	64,867		89,391
5	In-House Trainer Wages (c)	6,485	11,515		18,000
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 46,308	\$ 108,816	\$	\$ 155,124
10	SUM OF line 9, col. 1 and 2 (e)	\$ 155,124			

(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.

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	86
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	47
2. From other facilities (f)	
TOTAL TRAINED	133

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 prescrpts							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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,000	\$ 1,600,402	1
2	Cash-Patient Deposits	36,354	215,108	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,348,337	4,256,272	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		2,238	6
7	Other Prepaid Expenses		17,900	7
8	Accounts Receivable (owners or related parties)		151,217	8
9	Other(specify): <u>A/R other</u>		19,628	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,387,691	\$ 6,262,765	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		132,391	11
12	Long-Term Investments			12
13	Land	102,215	1,566,296	13
14	Buildings, at Historical Cost	5,070,602	20,229,924	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,397,887	5,386,720	16
17	Accumulated Depreciation (book methods)	(4,911,743)	(16,642,083)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	81,448	110,273	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(81,448)	(110,273)	20
21	Restricted Funds		1,186,000	21
22	Other Long-Term Assets (spc Escrow & loan fees		338,483	22
23	Other(specify): <u>CIP & CSV Insurance</u>		268,196	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,658,961	\$ 12,465,927	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,046,652	\$ 18,728,692	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 478,709	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,354	215,108	28
29	Short-Term Notes Payable		1,200,000	29
30	Accrued Salaries Payable		1,002,142	30
31	Accrued Taxes Payable (excluding real estate taxes)		101,618	31
32	Accrued Real Estate Taxes(Sch.IX-B)		90	32
33	Accrued Interest Payable		61,443	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Pension,Hlth Plan, etc.</u>		521,005	36
37	<u>Intercompany Account Payable</u>	6,798,523		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,834,877	\$ 3,580,115	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,545,128	40
41	Bonds Payable		2,105,000	41
42	Deferred Compensation		318,696	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,968,824	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,834,877	\$ 8,548,939	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,788,225)	\$ 10,179,753	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,046,652	\$ 18,728,692	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,546,870)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,546,870)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(241,355)	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)	\$ (241,355)	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)	\$ (2,788,225)	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		2
I. Revenue	Amount		
A. Inpatient Care			
1Gross Revenue -- All Levels of Care	\$ 5,686,733	1	
2Discounts and Allowances for all Levels	()	2	
3SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,686,733	3	
B. Ancillary Revenue			
4Day Care		4	
5Other Care for Outpatients		5	
6Therapy		6	
7Oxygen		7	
8SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8	
C. Other Operating Revenue			
9Payments for Education		9	
10Other Government Grants		10	
11CNA Training Reimbursements	114,099	11	
12Gift and Coffee Shop		12	
13Barber and Beauty Care		13	
14Non-Patient Meals		14	
15Telephone, Television and Radio		15	
16Rental of Facility Space	28,373	16	
17Sale of Drugs		17	
18Sale of Supplies to Non-Patients		18	
19Laboratory		19	
20Radiology and X-Ray		20	
21Other Medical Services	4,267	21	
22Laundry		22	
23SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 146,739	23	
D. Non-Operating Revenue			
24Contributions		24	
25Interest and Other Investment Income***	6,037	25	
26SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,037	26	
E. Other Revenue (specify):****			
27Settlement Income (Insurance, Legal, Etc.)		27	
28Gain on Sale of Vehicle & Equipment	2,200	28	
28a		28a	
29SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,200	29	
30TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,841,709	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31General Services	1,375,606	31	
32Health Care	3,038,809	32	
33General Administration	1,103,100	33	
B. Capital Expense			
34Ownership	235,977	34	
C. Ancillary Expense			
35Special Cost Centers		35	
36Provider Participation Fee	329,572	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,083,064	40	
41Income before Income Taxes (line 30 minus line 40)**	(241,355)	41	
42Income Taxes		42	
43NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (241,355)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44Medicaid - Net Inpatient Revenue	\$ 5,184,870	44	
45Private Pay - Net Inpatient Revenue	501,863	45	
46Medicare - Net Inpatient Revenue		46	
47Other-(specify)		47	
48Other-(specify)		48	
49TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,686,733	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 28
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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	1,972	2,080	\$ 56,441	\$ 27.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,042	7,048	162,990	23.13	3
4	Licensed Practical Nurses	15,270	18,822	382,664	20.33	4
5	CNAs & Orderlies					5
6	CNA Trainees	16,366	16,366	155,124	9.48	6
7	Licensed Therapist	460	460	30,404	66.10	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	695	829	21,416	25.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,586	10,451	106,812	10.22	15
16	Dishwashers					16
17	Maintenance Workers	8,958	10,597	162,727	15.36	17
18	Housekeepers	9,539	11,040	110,363	10.00	18
19	Laundry					19
20	Administrator	1,395	1,635	63,367	38.76	20
21	Assistant Administrator					21
22	Other Administrative	423	436	31,712	72.73	22
23	Office Manager	4,330	5,005	108,028	21.58	23
24	Clerical	1,806	2,081	23,176	11.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	31,160	34,760	557,203	16.03	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	107,345	119,145	1,228,386	10.31	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	215,347	240,755	\$ 3,200,813 *	\$ 13.29	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	60	\$ 2,392	1-3	35
36	Medical Director	120	24,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	197	6,500	10-3	38
39	Pharmacist Consultant	84	5,010	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) dental	245	12,264	10-3	46
47	psychologist/psychiatrist	407	43,610	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,113	\$ 93,776		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	Administrator		\$ 63,367	Workers' Compensation Insurance		\$ 72,313	IDPH License Fee		\$		
Corp. Admin Salaries	Administrator		31,712	Unemployment Compensation Insurance		16,205	Advertising: Employee Recruitment		5,109		
				FICA Taxes		235,693	Health Care Worker Background Check				
				Employee Health Insurance		344,357	(Indicate # of checks performed _____)				
				Employee Meals			Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*			Subscriptions		60		
				Pension		29,663	Fees		3,714		
				Employee Physical Exams		2,785	Dues		352		
				Applicant Referral Expense		99	Books & Periodicals		1,704		
				Other Employee Benefits		13,583					
							Less: Public Relations Expense	(	)		
							Non-allowable advertising	(	)		
							Yellow page advertising	(	)		
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		\$ 714,698	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 10,939		
(List each licensed administrator separately.)			\$ 95,079	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
B. Administrative - Other				Description	Line #	Amount	Description	Amount			
						\$	Out-of-State Travel	\$			
							In-State Travel				
							Seminar Expense				
							see page 26	6,587			
							Entertainment Expense	(			
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)				
(Attach a copy of any management service agreement)							TOTAL		\$ 6,587		
C. Professional Services											
Vendor/Payee	Type		Amount								
RSM McGladrey	Pension Plan		\$ 2,076								
Various	Computer/Programmer Cslt.		1,503								
Wipfli LLP	Audit		6,170								
Williams&McCarthy, DuaneMorris	Legal Fees		9,605								
TOTAL (agree to Schedule V, line 19, column 3)											
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 19,354								

*** 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?
If YES, give association name and amount.

no

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

no

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

no

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

yes
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?
If NO, attach a complete explanation.

yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

no

(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.
This amount is to be recorded on line 42 of Schedule V.

\$ 329,572

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

no

(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?
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.

no

(15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ n/a
Indicate the amount. \$

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

no

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

no

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?

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

no
\$

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

yes
Wipfli LLP

(18)

Have all costs which do not relate to the provision of long term care been adjusted out 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?
Attach invoices and a summary of services for all architect and appraisal fees.

n/a

SCHEDULE VII-A: BOARD MEMBER LISTING

<u>NAME</u>	<u>TITLE</u>	<u>TYPE OF SERVICE PROVIDED TO FACILIT</u>	<u>OWNERSHIP INTEREST IN</u>
Patrick Agnew	Director	Legal	Agnew Law Offices
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	
Carol Hartline	Director	Legal	Williams & McCarthy
Jack Kieckhefer	Director	Insurance	Kieckhefer & Nelson
Cyrus Oates	Director	N/A	
Randy L. Cooper	Vice Chairperson	Insurance	Williams Manny
Ben Holmstrom	Director	Construction	William Charles Connstruction
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
South Mulford	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.	Linda Thornbloom	VP	July 21, 2011	Dixon, IL	Autism & Asperger's SuperConference 2011	Future Horizons	177200	210.00
2.	Vickie Jenkins Dolores Robison Ashlie Judd Amanda Fisher Estella Dandridge Nathan Bjonbak	Home Coordinator/ Shift Supervisor Home Coordinator/ Shift Supervisor Home Coordinator/ Shift Supervisor Home Coordinator/ Shift Supervisor Home Coordinator/ Shift Supervisor Residential Serv. Provider II	August 16, 2011	Rockford, IL	Excelling as a Manager or Supervisor	Skillpath Seminars	W0738	834.00
3.	Terrie Garlow Lauri Krull Tom Cassady Joanna Grahm	Training Coordinatior QIDP Instructor Admin. Resd. & DT	September 30, 2011	Chicago, IL	Autisim/ Asperger's Syndrome Conference	Future Horizons	177665	620.00
4.	Linda Craig-Ellis	Nurse	September 28, 2011	Rockford, IL	Ultimate One Day Seminar	PESI HealthCare	177665	179.00
5.	Linda Craig-Ellis Cheri Poage Denise Sneek	Nurse Nurse Nurse	Nov. 4-5, 2011	Bloomington, IL	Central Illinois Conference	Developmental Disabilities Nurses Association	178108 178487	375.00 274.04
6.	Peggy Jones	LPN	November 1, 2011	Rockford, IL	Nursing Documentation Law & Ethics	Healthcare Enrichment Institute	178108	75.00
7.	Linda Thornbloom	VP	December 15, 2011	Rockford, IL	How to Manage Emotions & Excel Under Pressure	National Seminars Group	178108	199.00
8.	Melody Mills	Administrative Assistant	February 9, 2012	Rockford, IL	Assertiveness Skills for Manager & Supervisors	National Seminars Group	178108	199.00
9.	Jeffrey Hilden	Maintenance	November 7, 2011	Rockford, IL	OSHA Compliance 2012	Fred Pryor	178108	199.00
10.	Peggy Jones Denise Sneek	Nurse Nurse	Feb. 3, 2012	Schaumburg, IL	From Bedside to the Doorstep: Assessment, Diagnosis, & Treatment and other Neurological Disorders	PESI Healthcare	179123	378.00
11.	Becky Hinz Gene Engelkes Carissa Cassady Jessica Cook Peggy Brechon	QIDP QIDP QIDP QIDP QIDP/ RSD	Jan. 24, 2012	Alsip, IL	QSP Leadership	The ARC of Illinois	179123	750.00
12.	Aimee Kaopua-Hersey	Cook	March 24, 2012	Rockford, IL	Re-certification Food Service Sanitation	Safe Food Handlers Corporation	179588	105.00
13.	Brandi Feltz	Nurse	May 16, 2012	Rockford, IL	Why We Worry:Understanding and Treating Anxiety Disorders	Institute for Brain Poten (IBPCEU)	179693	79.00
14	Melody Mills	Administrative Assistant	February 9, 2012	Rockford, IL	Assertiveness for Managers & Supervisors	Padgett-Thompson	W9912	199.00
15.	Linda Thornbloom JoAnna Grahm	VP Admin. Resd. & DT	April 25-26, 2012	Lisle, IL	Dream, Empower, Achieve	The ARC of IL & The Autism Project	179693	500.00
16.	Tania Jones	Unit Clerk	May 16, 2012	Rockford, IL	Why We Worry: Understanding and Treating Anxiety Disorders	The Arc	180090	229.00
17.	Lauri Krull	RSD	May 15, 2012	Rockford, IL	PTI Conference in Rockford	Alzheimers Association	180404	169.00

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>
18.	Linda Thornbloom JoAnna Grahn	VP Admin. Resd. & DT	May 3, 2012	Schaumburg, IL	Communicate with Confidence and Present with Power	Cross Country EDU	180404	358.00
12.	Jim Hamilton	Director Emeritus	August 17, 2011 November 8, 2011	Springfield, IL Flordia	Meeting Meeting		177356 178108	655.58
							Total	<u><u>6,586.62</u></u>

RECLASSIFICATION - SCHEDULE V. COLUMN 5

SCHEDULE V		
Line #	Title	Amount
30	Depreciation	3,517.00
35	Equipment Rent	(3,517.00)
		<u>0</u>

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

30	Depreciation	2,117.00
36	Rent-Maintenance Building	(2,117.00)
		<u>0</u>

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

**FY12

Schedule of Federal Form 990 Reconciliation

Page 19, Line 41	(\$241,355)
	\$211,552 Related Organizational Net Income
Federal Form 990 Net Income	<u>(\$29,803)</u>

Asset Listing - VEHICLES

<u>Description</u>	<u>Date</u> <u>Acquired</u>	<u>Cost</u>		<u>Current Book</u> <u>Depreciation</u>	<u>Life</u> <u>in Years</u>	<u>Straight Line</u> <u>Depreciation</u>	<u>Adjustments</u>		<u>Accumulated</u> <u>Depreciation</u>
97 Ford Eldorado Bus	08/06/97	45,770.00	(A)	0.00	S/L - 3YR	0.00	(2,000.00)	(B)	45,770.00
99 Windstar	04/12/99	17,349.35		0.00	S/L - 3YR	0.00			17,349.35
04 Ford Crown Victoria	09/30/03	21,529.92		0.00	S/L - 3YR	0.00			21,529.92
04 Ford Truck F150	04/15/04	18,522.72		0.00	S/L - 3YR	0.00			18,522.72
Van Lift	06/17/04	3,735.00		0.00	S/L - 5YR	0.00			3,735.00
Van Lift	06/17/04	3,735.00		0.00	S/L - 5YR	0.00			3,735.00
04 Ford Freestar	08/25/04	18,347.26		0.00	S/L - 3YR	0.00			18,347.26
05 Ford Van E150	02/18/05	18,539.58		0.00	S/L - 3YR	0.00			18,539.58
2001 Jeep	05/02/05	9,629.00		0.00	S/L - 3YR	0.00			9,629.00
2006 Club Wagon	08/16/05	22,035.60		0.00	S/L - 3YR	0.00			22,035.60
05 Ford Eldorado	10/20/05	47,091.00		0.00	S/L - 3YR	0.00			47,091.00
97 Bus Repairs	11/30/05	10,152.19		0.00	S/L - 3YR	0.00			10,152.19
Bus Repairs	01/10/06	10,458.84		0.00	S/L - 3YR	0.00			10,458.84
06 Ford E350	10/11/06	22,040.40		0.00	S/L - 3YR	0.00			22,040.40
07 Ford Crown Vic	10/26/06	20,611.50		0.00	S/L - 3YR	0.00			20,611.50
06 Ford Eldorado	01/12/07	43,791.00		0.00	S/L - 3YR	0.00			43,791.00
99 GMC Truck	12/10/07	6,822.00		0.00	S/L - 3YR	0.00			6,822.00
08 Ford Econoline	05/30/08	23,420.00		0.00	S/L - 3YR	0.00			23,420.00
09 Ford Econoline	09/15/08	24,285.00		1,349.28	S/L - 3YR	1,349.28			24,285.00
09 Ford Econoline	09/26/08	25,679.00		1,426.46	S/L - 3YR	1,426.46			25,679.00
09 Ford Escape	10/06/08	22,741.00		1,895.23	S/L - 3YR	1,895.23			22,741.00
03 Jeep w/plow	02/10/09	12,155.00		2,363.44	S/L - 3YR	2,363.44			12,155.00
10 Ford Lift Van	01/21/10	54,594.00		18,198.00	S/L - 3YR	18,198.00			45,495.00
10 Ford Lift Van	01/21/10	54,594.00		18,198.00	S/L - 3YR	18,198.00			45,495.00
10 Ford Econoline	04/20/10	23,761.00		7,920.36	S/L - 3YR	7,920.36			17,820.81
11 Dodge Caravan	07/08/11	23,419.00		7,806.36	S/L - 3YR	7,806.36			7,806.36
12 Ford Taurus	09/16/11	26,852.00		7,458.90	S/L - 3YR	7,458.90			7,458.90
Less: A) Disposals		(45,770.00)							(45,770.00)
B) Gain on Sale of Fixed Assets						(2,000.00)			
C) Insurance Reimbursement									
TOTALS		<u>585,890.36</u>		<u>66,616.03</u>		<u>64,616.03</u>	<u>(2,000.00)</u>		<u>526,746.43</u>

Milestone, Inc. - ELMWOOD HEIGHTS # 0024943
Schedule of In-Service Training
FY 2012

<u>CHECK DATE</u>	<u>CHECK #</u>	<u>AMOUNT</u>	<u>VENDOR</u>	<u>DESCRIPTION</u>
11/04/11	177945	207.00	American Red Cross	CPR & First Aid Training Materials
08/05/11	177002	900.00	Northpointe Resource	HealthMatters Instructor Workshop-50% payment
11/04/11	177998	1,055.04	Northpointe Resource	HealthMatters Instructor Workshop-50% payment plus Mileage
05/11/12	180117	500.00	Forest City Behavior	Training by Erin Wade-Applied Behavior Analysis
	TOTAL	<u><u>\$ 2,662.04</u></u>		

ADDENDUM A