

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 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:

Facility Name & ID Number Milestone Elmwood Heights

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

III. STATISTICAL DATA

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

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	Skilled (SNF)			1
2	Skilled Pediatric (SNF/PED)			2
3	Intermediate (ICF)			3
4	84Intermediate/DD	84	30,744	4
5	Sheltered Care (SC)			5
6	ICF/DD 16 or Less			6
7	84TOTALS	84	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				10
11	ICF/DD	30,005		30,005	11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	30,005		30,005	14

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

D. How many bed-hold days during this year were paid by the Department? 32 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO 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 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

MODIFIED

ACCRUAL X CASH* CASH*

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

Tax Year: 06/30/16 Fiscal Year: 06/30/16

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

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

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

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

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

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

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			177,670	177,670	5,646	183,316	(2,400)	180,916			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			457	457		457		457			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,346	7,346	(3,292)	4,054		4,054			35
36	Other (specify):* Alloc. Maint. Bldg			2,354	2,354	(2,354)						36
37	TOTAL Ownership			187,827	187,827		187,827	(2,400)	185,427			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			334,692	334,692		334,692		334,692			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			334,692	334,692		334,692		334,692			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,597,250	1,105,160	1,854,478	6,556,890		6,556,890	(2,400)	6,554,490			45

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

VI. ADJUSTMENT DETAIL

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

	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				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,400)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,400)		\$	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
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,400)		37

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

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

		1 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		\$		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: 07/01/15 Ending: 06/30/16

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

	Operating Expenses	PAGES	PAGE	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
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	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	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	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)	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	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 23 & 24						

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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			\$			\$	\$	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

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

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Milestone, Inc. - Central Office
Street Address 4060 McFarland Road
City / State / Zip Code Rockford, IL 61111
Phone Number (815) 654-6100
Fax Number (815) 654-6444

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary Wages	Days	57,670	4	\$ 251,502	\$ 251,502	30,660	\$ 133,710	1
2	1	Dietary Supplies	Days	118,990	34	77,201		30,660	19,892	2
3	2	Food Purchase	Days	118,990	34	1,302,467		30,660	335,605	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	183,774	183,774	91,980	121,233	4
5	6	Maintenance Wages	Level of Care/Days	298,570	36	442,431	442,431	91,980	136,299	5
6	21	Clerical Wages	Level of Care/Days	9,360,000	38	678,618	678,618	2,207,520	160,049	6
7	21	Office Supplies	Level of Care/Days	9,360,000	38	162,567		2,207,520	38,341	7
8	21	Telephone	Level of Care/Days	9,360,000	38	166,753		2,207,520	39,328	8
9	22	Fringe Benefits	Wages	16,783,866	42	4,182,410		3,597,251	896,407	9
10	35	Rent-Computer	Level of Care/Days	9,360,000	38	13,959		2,207,520	3,292	10
11	36	Rent Maintenance Building	Level of Care/Days	9,360,000	38	9,981		2,207,520	2,354	11
12										12
13										13
14										14
15		See Addendum A								15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,471,663	\$ 1,556,325		\$ 1,886,510	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

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

FACILITY NAME Milestone Elmwood Heights COUNTY Winnebago
FACILITY IDPH LICENSE NUMBER 0024943
CONTACT PERSON REGARDING THIS REPORT _____
TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

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.

A. Square Feet: 40,570

B. General Construction Type: Exterior Brick Frame Number of Stories

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Milestone Elmwood Heights

0024943

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Furnace	1994	\$ 40,882	\$	20	\$	\$	\$ 40,882	37
38 Telephones	1994	3,111		12			3,111	38
39 Air Handler	1995	1,668		7			1,668	39
40 Above Ground Tank	1995	4,825		20			4,825	40
41 Concrete	1995	5,575	26	20	26		5,575	41
42 Furnace	1995	9,618	68	20	68		9,618	42
43 Roof	1995	1,290	15	20	15		1,290	43
44 Kitchen Sink	1995	1,300	21	20	21		1,300	44
45 Road Stone	1996	1,120		5			1,120	45
46 Air Conditioner	1996	2,476	124	20	124		2,446	46
47 Tile	1996	360		5			360	47
48 Sinks	1997	6,470		15			6,470	48
49 Flood Lights	1997	2,550	128	20	128		2,434	49
50 Air Conditioner	1997	4,055	203	20	203		3,870	50
51 Sidewalk	1997	6,691	335	20	335		6,357	51
52 Black Top Parking Lot	1997	85,125		15			85,125	52
53 Smoke Detectors	1997	16,100		15			16,100	53
54 Roof	1997	7,070	354	20	354		6,629	54
55 Counters	1997	3,706		15			3,706	55
56 Fire Alarm System	1998	3,660	183	20	183		3,370	56
57 Acoustical Ceiling	1998	1,650	83	20	83		1,520	57
58 Sidewalk Repair	1998	5,660	283	20	283		5,093	58
59 Duct Work	1998	1,017	51	20	51		916	59
60 Tile Repair	1998	650		5			650	60
61 Air Conditioner	1998	2,742		15			2,742	61
62 Carpet	1998	1,544		7			1,544	62
63 Driveway Repairs	1998	2,372		15			2,372	63
64 Roof	1998	2,000	100	20	100		1,774	64
65 Dry Valve	1998	1,540		10			1,540	65
66 Roof	1999	5,970	299	20	299		5,225	66
67 Dry Valve	1999	1,815		10			1,815	67
68 Tile	1999	2,600		5			2,600	68
69 Acoustical Ceiling	2000	6,750	338	20	338		5,427	69
70 TOTAL (lines 4 thru 69)		\$ 414,748	\$ 2,611		\$ 2,611	\$	\$ 410,260	70

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

Facility Name & ID Number Milestone Elmwood Heights

0024943

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 414,748	\$ 2,611		\$ 2,611	\$	\$ 410,260	1
2	Carpet	2000	12,538		5			12,538	2
3	Counter Tops	2000	1,622	36	15	36		1,622	3
4	Automatic Doors	2002	4,148		5			4,148	4
5	Tile	2002	2,760		5			2,760	5
6	Water Heater	2002	4,200		10			4,200	6
7	Water Heater	2002	8,135		5			8,135	7
8	Carpet	2002	2,232		5			2,232	8
9	Tile	2002	2,160		5			2,160	9
10	Cabinets	2003	2,449	163	15	163		2,137	10
11	Sump Pump	2003	7,218		10			7,218	11
12	Carpet	2003	8,950		5			8,950	12
13	Air Conditioner	2003	4,705		10			4,705	13
14	Carpet	2003	5,310		5			5,310	14
15	Cabinets	2003	2,409	161	15	161		2,075	15
16	Water Heater	2003	3,694		5			3,694	16
17	Acoustical Ceilings	2004	11,040	552	20	552		6,900	17
18	Carpet	2004	2,094		7			2,094	18
19	Remove ceiling tile & install drywall ceilings	2004	20,380	1,359	15	1,359		16,870	19
20	Carpet	2004	5,058		7			5,058	20
21	Thermostatic control system for heat and air	2004	29,322	1,466	20	1,466		17,960	21
22	Heater	2004	4,660		10			4,660	22
23	Cabinets	2004	8,204	547	15	547		6,609	23
24	Carpet	2004	27,534		7			27,534	24
25	Smoke & Heat Detectors	2004	6,945		10			6,945	25
26	Vinyl Floor	2004	7,242		7			7,242	26
27	Vinyl Floor	2005	5,102		7			5,102	27
28	Cabinets	2005	20,031	1,335	15	1,335		15,067	28
29	Counter Tops	2005	3,097	207	15	207		2,358	29
30	Ceramic Tile	2005	3,377		7			3,377	30
31	Water Pipe Repair	2005	8,955	358	25	358		3,940	31
32	Roof	2005	6,425	321	20	321		3,534	32
33	Replace Sidewalk	2005	10,808	540	20	540		5,854	33
34	TOTAL (lines 1 thru 33)		\$ 667,552	\$ 9,656		\$ 9,656	\$	\$ 623,248	34

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

Facility Name & ID Number Milestone Elmwood Heights

0024943

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

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

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

Facility Name & ID Number Milestone Elmwood Heights

0024943

Report Period Beginning:

07/01/15

Ending:

06/30/16

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

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

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

XI. OWNERSHIP COSTS (continued)

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

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

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	see page 27			\$ 663,036	\$ 44,946	\$ 42,546	\$ (2,400)		\$ 629,140	76
77										77
78										78
79										79
80	TOTALS			\$ 663,036	\$ 44,946	\$ 42,546	\$ (2,400)		\$ 629,140	80

E. Summary of Care-Related Assets

	1	Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,071,319	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 183,316	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 180,916	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,400)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,730,070	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	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: \$ 4,053 Description: Copier/Fax/Printer
(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

* 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	17,472	34,990		52,462
4	Clinical Wages (b)	53,503	68,885		122,388
5	In-House Trainer Wages (c)	6,729	11,271		18,000
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 77,704	\$ 115,146	\$	\$ 192,850
10	SUM OF line 9, col. 1 and 2 (e)	\$ 192,850			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	88
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	77
2. From other facilities (f)	
TOTAL TRAINED	165

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

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,045,451)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,045,451)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(735,717)	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)	\$ (735,717)	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)	\$ (4,781,168)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Milestone Elmwood Heights

0024943

Report Period Beginning: 07/01/15

Ending:

06/30/16

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

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,557,838	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,557,838	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		10
11	CNA Training Reimbursements	246,398	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	9,173	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,530	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 259,101	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Gain on Sale of Veh and Recycled Metal</u>	4,234	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,234	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,821,173	30

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

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

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? no If not, please attach a reconciliation. see page 26

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	214	231	\$ 6,038	\$ 26.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,590	9,766	239,372	24.51	3
4	Licensed Practical Nurses	17,482	19,609	419,436	21.39	4
5	CNAs & Orderlies					5
6	CNA Trainees	20,343	20,343	192,850	9.48	6
7	Licensed Therapist	466	466	30,295	65.01	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	700	835	22,215	26.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,975	10,136	111,495	11.00	15
16	Dishwashers					16
17	Maintenance Workers	7,899	8,932	136,299	15.26	17
18	Housekeepers	10,250	12,087	121,233	10.03	18
19	Laundry					19
20	Administrator	1,368	1,639	66,239	40.41	20
21	Assistant Administrator					21
22	Other Administrative	463	476	34,517	72.51	22
23	Office Manager	4,708	5,456	125,533	23.01	23
24	Clerical	1,815	2,064	23,569	11.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	31,474	35,872	573,598	15.99	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	127,728	139,548	1,494,561	10.71	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	242,475	267,460	\$ 3,597,250 *	\$ 13.45	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	4	\$ 140	1-3	35
36	Medical Director	120	27,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	104	3,422	10-3	38
39	Pharmacist Consultant	72	4,320	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	245	12,264	10-3	46
47	Psychologist/Psychiatrist	541	59,013	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,086	\$ 106,159		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Milestone Elmwood Heights

0024943

Report Period Beginning: 07/01/15

Ending: 06/30/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Thornbloom			\$ 66,239
Corp. Admin Salaries			34,517
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,756

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
RSM McGladrey	Pension Plan	\$ 2,025
Various	Computer/Programmer Cslt.	976
Wipfli LLP	Audit	5,679
Williams&McCarthy, DuaneMorris	Legal Fees	1,614
Peggy Brechon	Administrative Consultant	2,250
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 12,544

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 101,351
Unemployment Compensation Insurance	
FICA Taxes	262,390
Employee Health Insurance	515,024
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical Exams	3,416
Other Employee Benefits	10,143
Applicant Referral	4,083
TOTAL (agree to Schedule V, line 22, col.8)	\$ 896,407

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	17,218
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Dues	2,099
Fees	5,640
Books & Periodicals	60
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,017

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	865
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 865

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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?

no

If YES, have these costs been properly adjusted out of the cost report?
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

no

If YES, what is the capacity?
- (5) Have you properly capitalized all major repairs and equipment purchases?

yes

What was the average life used for new equipment added during this period?

5-10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ n/a

Line
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

yes

If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement?

no

If YES, give effective date of lease.
- (9) Are you presently operating under a sublease agreement?

YES

X

NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 334,692

This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

no

If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

no

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee 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?

yes

g. Does the facility transport residents to and from day training?

no

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

\$
- (17) Has an audit been performed by an independent certified public accounting firm?

yes

Firm Name:

WIPFLI LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

yes

Attach invoices and a summary of services for all architect and appraisal fees

SCHEDULE VII-A: BOARD MEMBER LISTING

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

SCHEDULE VII-A: RELATED PARTIES

<u>MILESTONE, INC.</u>	RESIDENTIAL		TYPE OF
	<u>BEDS</u>	<u>CITY</u>	<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.I.L.A. Services
Orchard	8	Rockford	C.I.L.A. Services
Training Center	N/A	Rockford	Developmental Training
Industries	N/A	Loves Park	Developmental Training
RocVale Childrens Home	50	Rockford	Children's Group Home DD
Shattuck	5	Rockford	C.I.L.A. Services
Eggleston	5	Rockford	C.I.L.A. Services
Dierks	8	Rockford	C.I.L.A. Services
Geneva	5	Rockford	C.I.L.A. Services
C.I.L.A.	22	Rockford	C.I.L.A. Services
Windcloud	5	Rockford	C.I.L.A. Services
Prospect	5	Rockford	C.I.L.A. Services
Hanford	5	Rockford	C.I.L.A. Services
Rural	5	Rockford	C.I.L.A. Services
Flintridge	5	Rockford	C.I.L.A. Services
Old Golf	8	Loves Park	C.I.L.A. Services
Creekside	5	Rockford	C.I.L.A. Services
Hermitage	5	Rockford	C.I.L.A. Services
Javelin II	5	Rockford	C.I.L.A. Services
Windpoint	5	Rockford	C.I.L.A. Services
Weymouth	5	Rockford	C.I.L.A. Services
Fleetwood	5	Rockford	C.I.L.A. Services
Stornway	5	Rockford	C.I.L.A. Services
Shiloh	6	Rockford	C.I.L.A. Services
Black Oak	5	Rockford	C.I.L.A. Services
Donna Drive	8	Rockford	C.I.L.A. Services
Respite Services	N/A	Rockford	Respite Services
Sawgrass	6	Rockford	C.I.L.A. Services
Crested Butte	6	Rockford	C.I.L.A. Services
Dental Program	N/A	Rockford	Dental Services
Thyme	7	Rockford	C.I.L.A. Services
Tulip	5	Rockford	C.I.L.A. Services
Packard	5	Rockford	C.I.L.A. Services
Apawamis	4	Rockford	C.I.L.A. Services
Southbridge	5	Rockford	C.I.L.A. Services
South Mulford	8	Rockford	C.I.L.A. Services
Commonwealth	8	Rockford	C.I.L.A. Services
HUD Project #071-EH003	N/A	Rockford	Housing
HUD Project #071-EH059	N/A	Rockford	Housing
HUD Project #071-EH178	N/A	Rockford	Housing
HUD Project #071-HD160	N/A	Rockford	Housing
HUD Project #071-HD169	N/A	Rockford	Housing
Bingo	N/A	Rockford	Bingo

RECLASSIFICATION - SCHEDULE V. COLUMN 5

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

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

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

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

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Schedule of Federal Form 990 Reconciliation

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

Asset Listing - VEHICLES

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

Legal Fees

Williams & McCarthy

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

Duane Morris, LLP

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