

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0024943</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Milestone Elmwood Heights</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/19</u> to <u>6/30/20</u> 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.																							
Address: <u>2662 Elmwood Road</u> <u>Rockford</u> <u>61103</u>																									
Number City Zip Code																									
County: <u>Winnebago</u>																									
Telephone Number: <u>(815) 877-7001</u> Fax # <u>(815) 654-6445</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Lisa Munson</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Lisa Munson</u>	(Title) <u>CFO</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Lisa Munson</u>																								
	(Title) <u>CFO</u>																								
	(Date) _____																								
Paid Preparer	(Signed) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>09/01/79</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501 (c) 3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501 (c) 3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
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IRS Exemption Code <u>501 (c) 3</u>	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Lisa Munson</u> Telephone Number: <u>(815) 654-6100</u>																									
Email Address: _____																									

Facility Name & ID Number Milestone Elmwood Heights

0024943 Report Period Beginning: 7/1/19 Ending: 6/30/20

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	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	28,052			28,052	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,052			28,052	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.24%

D. How many bed reserve days during this year were paid by the Department? 5 (Do not include bed reserve 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

ACCRUAL X MODIFIED CASH* CASH*

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

Tax Year: 06/30/20 Fiscal Year: 06/30/20 * All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Milestone Elmwood Heights # 0024943 Report Period Beginning: 7/1/19 Ending: 6/30/20
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	196,723	17,629		214,352		214,352		214,352			1
2	Food Purchase		333,008		333,008		333,008		333,008			2
3	Housekeeping	161,355	90,016	3,049	254,420		254,420		254,420			3
4	Laundry		14,094		14,094		14,094		14,094			4
5	Heat and Other Utilities			171,004	171,004		171,004		171,004			5
6	Maintenance	163,946	247,500	18,177	429,623		429,623		429,623			6
7	Other (specify):* Security System Mobile Stops			2,500	2,500		2,500		2,500			7
8	TOTAL General Services	522,024	702,247	194,730	1,419,001		1,419,001		1,419,001			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	4,444,913	461,867	135,775	5,042,555		5,042,555		5,042,555			10
10a	Therapy											10a
11	Activities		34,672		34,672		34,672		34,672			11
12	Social Services	29,288			29,288		29,288		29,288			12
13	CNA Training	169,332			169,332		169,332		169,332			13
14	Program Transportation		29,305	1,965	31,270		31,270		31,270			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,643,533	525,844	173,740	5,343,117		5,343,117		5,343,117			16
	C. General Administration											
17	Administrative	86,675			86,675		86,675		86,675			17
18	Directors Fees											18
19	Professional Services			16,119	16,119		16,119		16,119			19
20	Dues, Fees, Subscriptions & Promotions			23,744	23,744		23,744		23,744			20
21	Clerical & General Office Expenses	212,167	36,095	61,237	309,499		309,499		309,499			21
22	Employee Benefits & Payroll Taxes			1,180,931	1,180,931		1,180,931		1,180,931			22
23	Inservice Training & Education			9,228	9,228		9,228		9,228			23
24	Travel and Seminar			2,397	2,397		2,397		2,397			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			75,312	75,312		75,312		75,312			26
27	Other (specify):*											27
28	TOTAL General Administration	298,842	36,095	1,368,968	1,703,905		1,703,905		1,703,905			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,464,399	1,264,186	1,737,438	8,466,023		8,466,023		8,466,023			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			173,490	173,490	6,745	180,235	(2,000)	178,235			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,359	13,359		13,359		13,359			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,396	14,396	(3,933)	10,463		10,463			35
36	Other (specify):* Alloc. Maint Bldg			2,812	2,812	(2,812)						36
37	TOTAL Ownership			204,057	204,057		204,057	(2,000)	202,057			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			537,080	537,080		537,080		537,080			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			537,080	537,080		537,080		537,080			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,464,399	1,264,186	2,478,575	9,207,160		9,207,160	(2,000)	9,205,160			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	(2,000)	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)	\$ (2,000)		\$	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))	\$ (2,000)		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:

7/1/19

Ending:

6/30/20

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: 7/1/19 Ending: 6/30/20

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	(2,000)	0	0	0	0	0	0	0	0	0	0	(2,000)	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	(2,000)	0	0	0	0	0	0	0	0	0	0	(2,000)	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)	(2,000)	0	0	0	0	0	0	0	0	0	0	(2,000)	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
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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: 7/1/19 Ending: 6/30/20

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	48,545	4	\$ 311,478	\$ 311,478	30,660	\$ 196,723	1
2	1	Dietary Supplies	Days	106,945	33	61,492		30,660	17,629	2
3	2	Food Purchase	Days	106,945	33	1,161,565		30,660	333,008	3
4	3	Housekeeping Wages	Level of Care/Days	124,465	5	218,342	218,342	91,980	161,355	4
5	6	Maintenance Wages	Level of Care/Days	265,355	35	472,972	472,972	91,980	163,946	5
6	21	Clerical Wages	Level of Care/Days	7,905,840	37	759,840	759,840	2,207,520	212,167	6
7	21	Office Supplies	Level of Care/Days	7,905,840	37	129,269		2,207,520	36,095	7
8	21	Telephone,internet&cable	Level of Care/Days	7,905,840	37	219,308		2,207,520	61,237	8
9	22	Fringe Benefits	Wages	19,483,506	41	4,210,650	4,210,650	5,464,399	1,180,931	9
10	35	Rent-Computer	Level of Care/Days	7,905,840	37	14,085		2,207,520	3,933	10
11	36	Rent Maintenance Building	Level of Care/Days	7,905,840	37	10,071		2,207,520	2,812	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	TOTALS					\$ 7,569,072	\$ 5,973,282		\$ 2,369,836	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	Illinois Bank & Trust		X	Line of Credit			2,500,000		5/28/20	Floating Prime	12,245		6
7	Illinois Bank & Trust		X	Line of Credit-Vehicles			80,000	64,511	5/11/24	5.5000	1,114		7
8													8
9	TOTAL Facility Related						\$ 2,580,000	\$ 64,511				\$ 13,359	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$ 2,580,000	\$ 64,511				\$ 13,359	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015		8	
	2016		9	
	2017		10	
	2018		11	
	2019		12	
		FOR BHF USE ONLY		
		13	FROM R. E. TAX STATEMENT FOR 2019 \$	13
		14	PLUS APPEAL COST FROM LINE 5 \$	14
		15	LESS REFUND FROM LINE 6 \$	15
		16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

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

FACILITY NAME Milestone 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 2019 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 2019.

B. Real Estate Tax Cost Allocations

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

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

Page 10A

A. Square Feet: 40,570

B. General Construction Type: Exterior BrickFrame Cement block

Number of Stories one

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Project	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	Door Locking System			1978	14,081		10			14,081
11	Floor Tile			1979	2,870		10			2,870
12	Landscaping			1980	25,659		5			25,659
13	Sign			1980	725		5			725
14	Chain Link Fence			1980	1,377		5			1,377
15	Landscaping			1980	4,071		5			4,071
16	Storage Building			1980	8,471		5			8,471
17	Landscaping			1981	595		5			595
18	Bike Path, Parking Lot, Basketball Court			1982	22,944		15			22,944
19	Parking Lot Repairs			1982	2,216		15			2,216
20	Room Remodeling			1983	4,312		10			4,312
21	Concrete Slab for Shelter			1984	6,751		15			6,751
22	Park Shelter			1984	13,058		15			13,058
23	Driveway Maintenance			1984	2,201		5			2,201
24	Sewer Repair			1984	1,195		20			1,195
25	Landscaping-Trees			1985	1,677		5			1,677
26	Landscaping-Plantscape			1986	4,117		10			4,117
27	Sidewalk Concrete			1988	2,930		20			2,930
28	Sidewalk Improvements			1990	5,490		20			5,490
29	Parking Lot			1990	3,097		15			3,097
30	Parking Lot Repairs			1991	2,430		15			2,430
31	Roof			1992	3,969		20			3,969
32	Outdoor Drinking Fountain			1992	1,998		20			1,998
33	Telephone System			1992	9,600		12			9,600
34	Roof Repairs			1993	6,965		20			6,965
35	Sump Pump			1993	4,721		10			4,721
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Milestone Elmwood Heights

0024943

Report Period Beginning:

7/1/19

Ending:

6/30/20

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	\$	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		20			5,575	41
42	Furnace	1995	9,618		20			9,618	42
43	Roof	1995	1,290		20			1,290	43
44	Kitchen Sink	1995	1,300		20			1,300	44
45	Road Stone	1996	1,120		5			1,120	45
46	Air Conditioner	1996	2,476		20			2,476	46
47	Tile	1996	360		5			360	47
48	Sinks	1997	6,470		15			6,470	48
49	Flood Lights	1997	2,550		20			2,550	49
50	Air Conditioner	1997	4,055		20			4,055	50
51	Sidewalk	1997	6,691		20			6,691	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		20			7,070	54
55	Counters	1997	3,706		15			3,706	55
56	Fire Alarm System	1998	3,660		20			3,660	56
57	Acoustical Ceiling	1998	1,650		20			1,650	57
58	Sidewalk Repair	1998	5,660		20			5,660	58
59	Duct Work	1998	1,017		20			1,017	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		20			2,000	64
65	Dry Valve	1998	1,540		10			1,540	65
66	Roof	1999	5,970		20			5,970	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	269	20	269		6,708	69
70	TOTAL (lines 4 thru 69)		\$ 402,032	\$ 269		\$ 269	\$	\$ 401,990	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:

7/1/19

Ending:

6/30/20

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		\$ 402,032	\$ 269		\$ 269		\$ 401,990	1
2	Carpet	2000	12,538		5			12,538	2
3	Counter Tops	2000	1,622		15			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		15			2,449	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		15			2,409	15
16	Water Heater	2003	3,694		5			3,694	16
17	Acoustical Ceilings	2004	11,040	552	20	552		9,108	17
18	Carpet	2004	2,094		7			2,094	18
19	Remove ceiling tile & install drywall ceilings	2004	20,380		15			20,380	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		23,825	21
22	Heater	2004	4,660		10			4,660	22
23	Cabinets	2004	8,204		15			8,204	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		15			19,073	28
29	Counter Tops	2005	3,097		15			2,977	29
30	Ceramic Tile	2005	3,377		7			3,377	30
31	Water Pipe Repair	2005	8,955	358	25	358		5,373	31
32	Roof	2005	6,425	321	20	321		4,818	32
33	Replace Sidewalk	2005	10,808	540	20	540		8,015	33
34	TOTAL (lines 1 thru 33)		\$ 654,836	\$ 3,506		\$ 3,506		\$ 638,305	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:

7/1/19

Ending:

6/30/20

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		\$ 654,836	\$ 3,506		\$ 3,506	\$	\$ 638,305	1
2	<u>Furnaces(8)</u>	2006	20,135	1,007	20	1,007		14,440	2
3	<u>Office Remodel</u>	2006	3,870	258	15	258		3,698	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		19,167	5
6	<u>Furnace & Air Conditioner</u>	2006	3,295	165	20	165		2,334	6
7	<u>Acoustical Ceiling</u>	2006	6,000	300	20	300		4,250	7
8	<u>Activity Room Remodel</u>	2006	8,980	599	15	599		8,481	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		8,789	11
12	<u>Concrete Curb&Gutter</u>	2006	14,906	745	20	745		10,150	12
13	<u>Furnace</u>	2007	9,162	458	20	458		6,031	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		10			3,325	18
19	<u>Furnaces(4)</u>	2007	9,514	476	20	476		6,025	19
20	<u>Doors</u>	2007	16,161	1,077	15	1,077		13,557	20
21	<u>Carpet</u>	2008	5,429		7			5,429	21
22	<u>Blacktop Parking Lot</u>	2007	78,292	5,220	15	5,220		64,374	22
23	<u>Fans & Supplies</u>	2008	6,849	342	20	342		4,024	23
24	<u>Service Fire Alarm System</u>	2008	6,848		10			6,848	24
25	<u>Concrete Ramp</u>	2008	4,136	207	20	207		2,429	25
26	<u>Service Fire Alarm System</u>	2009	3,370		10			3,370	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		376,805	28
29	<u>Blacktop Parking Lot</u>	2009	11,142	743	15	743		8,233	29
30	<u>Sidewalks</u>	2009	6,704	335	20	335		3,715	30
31	<u>Double Steel Doors</u>	2009	3,320	221	15	221		2,323	31
32	<u>Carpet</u>	2010	4,878		5			4,878	32
33	<u>Carpet</u>	2010	13,756		5			13,756	33
34	TOTAL (lines 1 thru 33)		\$ 1,864,864	\$ 51,647		\$ 51,647	\$	\$ 1,321,645	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:

7/1/19

Ending:

6/30/20

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		\$ 1,864,864	\$ 51,647		\$ 51,647	\$	\$ 1,321,645	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		31,528	4
5	Shingles	2010	4,435	296	15	296		2,957	5
6	Blacktop	2010	8,348	557	15	557		5,426	6
7	Air Conditioner	2011	3,696	185	20	185		1,679	7
8	Pipe Repair	2011	15,085	754	20	754		6,851	8
9	Sidewalk	2011	8,656	433	20	433		3,895	9
10	Parking lot	2011	182,656	12,177	15	12,177		105,563	10
11	Fire Protection	2011	4,156	416	10	416		3,567	11
12	Water Drainage Lines	2011	3,500	233	15	233		1,983	12
13	Doors&Frames/2 for laundry rooms, 1 for mechanical room (also i	2011	5,107	340	15	340		2,894	13
14	Water Heaters (4)	2012	15,526		5			15,526	14
15	Pharmacy Remodel/electrical,counter shutter,windows,cabinetry,a	2012	32,834	2,189	15	2,189		17,876	15
16	PVC Conduit for Pole Lighting	2011	4,350	435	10	435		3,480	16
17	Carpet/living area & bedrooms for 63,64,65,66,67,68 as needed	2012	3,980		5			3,980	17
18	Automatic Door /Training room door	2012	8,933	893	10	893		6,700	18
19	Repair to Heating and Cooling Unit/removed & repiped hot water	2013	3,843		5			3,843	19
20	Vinyl Flooring&adhesive/kitchens,bathrooms & some bedrooms fo	2013	9,380		5			9,380	20
21	3 Automatic Doors-Activity Room, Kitchen 65&66	2013	7,637	764	10	764		5,600	21
22	6 automatic Doors/main entrance,back entrance,kitchen entry fo	2013	17,764	1,776	10	1,776		12,286	22
23	Seal black top and restriped parking lot	2013	7,572	757	10	757		5,237	23
24	sidewalk for 63 @ front door area and rear, sidewalk for maintena	2013	3,059	153	20	153		1,033	24
25	TheraPure Pipeless Height Adjustable Supine Tub	2013	11,844	1,184	10	1,184		7,995	25
26	Vinyl Flooring&adhesive/kitchens,bathrooms & some bedrooms fo	2013	5,319		5			5,319	26
27	Vinyl Flooring&adhesive/kitchens,bathrooms & some bedrooms fo	2014	3,861		5			3,861	27
28	Vinyl Flooring&adhesive/kitchens,bathrooms & some bedrooms fo	2014	6,105	305	5	305		6,105	28
29	Install Frame and Door in the nursing department bewtween the 2	2014	4,296	430	10	430		2,399	29
30	Vinyl Flooring&adhesive/kitchens,bathrooms & some bedrooms fo	2014	3,715	558	5	558		3,715	30
31	Furnish and install two boilers and piping for the Core Building	2015	65,188	3,259	20	3,259		15,754	31
32	Carpet/living area & bedrooms for 63,64,65,66,67,68 as needed	2015	5,380	1,076	5	1,076		5,200	32
33	Blacktop seal and repair	2016	5,316	532	10	532		2,126	33
34	TOTAL (lines 1 thru 33)		\$ 2,392,866	\$ 84,450		\$ 84,450	\$	\$ 1,645,346	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:

7/1/19

Ending:

6/30/20

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 12D, Carried Forward		\$ 2,392,866	\$ 84,450		\$ 84,450	\$	\$ 1,645,346	1
2	HVAC unit	2016	8,140	407	20	407		1,594	2
3	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2016	4,905	981	5	981		3,842	3
4	Electrical work, (install ground boxes, 200'2"PVC conduit, pull ne	2016	3,853	771	5	771		2,954	4
5	Air compressor, tank, air dryer	2017	4,642	928	5	928		3,172	5
6	Roof replacement	2017	41,131	2,057	20	2,057		6,512	6
7	duct work, venting (replace some venting on the furnace and wate	2017	4,475	447	10	447		1,417	7
8	Water Heater	2017	3,803	761	5	761		2,409	8
9	Exhaust Fan & one intake hood on the roof, a inlet grill above dry	2017	12,900	1,290	10	1,290		3,655	9
10	Roof replacement on covered walk way	2017	7,248	725	10	725		2,054	10
11	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2018	4,936	987	5	987		2,386	11
12	Furnace	2018	3,425	171	20	171		400	12
13	Water Heater	2018	3,988	798	5	798		1,795	13
14	Light Poles and LED light heads	2018	3,750	375	10	375		812	14
15	HVAC unit x2	2018	8,370	418	20	418		907	15
16	HVAC unit x2	2018	8,980	449	20	449		898	16
17	Water Heater	2018	4,266	853	5	853		1,706	17
18	Doors x 4, 2 lounge rooms doors, 1 mechanical room door, & 1 kit	2019	21,080	2,108	10	2,108		2,108	18
19	Water Heater	2019	4,535	906	5	906		906	19
20	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2019	3,065	460	5	460		460	20
21	Blacktop repair, crack fill hot tar using Crackmaster Supreme and	2019	6,895	517	10	517		517	21
22	Repair Electrical Connection Tamper Switch & new Bollards	2019	16,590	968	10	968		968	22
23	Run off Water pit, removed 2 boxes and wiring that supplied pum	2019	11,261	656	10	656		656	23
24	Musical park/playground. Benches, freenotes flower collection, ba	2020	12,018	1,202	5	1,202		1,202	24
25	Water Heater	2020	4,661	466	5	466		466	25
26	Whirlpool Tub with adjustable height & Air Spa	2020	11,400	474	10	474		474	26
27	4 HVAC units	2015	16,390	1,080	10	1,080		8,058	27
28	Allocated Maintenance Building			2,812		2,812			28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,629,573	\$ 108,517		\$ 108,517	\$	\$ 1,697,674	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	\$ 113,929	\$ 23,529	\$ 23,529	\$	5-10 yrs	\$ 62,975	71
72	Current Year Purchases	45,211	3,471	3,471		3-5 yrs	3,471	72
73	Fully Depreciated Assets	872,669				5-10 yrs	872,669	73
74	allocated computer		3,933	3,933				74
75	TOTALS	\$ 1,031,809	\$ 30,933	\$ 30,933	\$		\$ 939,115	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			\$ 700,079	\$ 40,785	\$ 38,785	\$ (2,000)		\$ 655,628	76
77										77
78										78
79										79
80	TOTALS			\$ 700,079	\$ 40,785	\$ 38,785	\$ (2,000)		\$ 655,628	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)	\$ 4,463,676	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 180,235	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,235	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,000)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,292,417	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: \$ 10,463
- 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
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	15,347	34,842		50,189
4	Clinical Wages (b)	31,201	69,852		101,053
5	In-House Trainer Wages (c)	6,240	11,850		18,090
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 52,788	\$ 116,544	\$	\$ 169,332
10	SUM OF line 9, col. 1 and 2 (e)	\$ 169,332			

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	81
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	57
2. From other facilities (f)	
TOTAL TRAINED	138

(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.)

12345678										
	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
	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	\$	\$ 3,107,428	1
2	Cash-Patient Deposits	160,056	647,990	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,279,994	2,027,709	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		13,221	6
7	Other Prepaid Expenses		33,525	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		25,106	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,440,050	\$ 5,854,980	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	102,215	1,677,335	13
14	Buildings, at Historical Cost	5,464,111	24,429,444	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,735,562	6,033,268	16
17	Accumulated Depreciation (book methods)	(6,131,712)	(22,723,015)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,074,037	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Cash Surrender Value of Life Ins</u>		668,502	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,170,176	\$ 11,159,571	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,610,226	\$ 17,014,550	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 263,776	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	160,056	647,990	28
29	Short-Term Notes Payable		372,947	29
30	Accrued Salaries Payable		1,008,668	30
31	Accrued Taxes Payable (excluding real estate taxes)		379,840	31
32	Accrued Real Estate Taxes(Sch.IX-B)		79	32
33	Accrued Interest Payable		3,085	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Pension, other benefits</u>		199,299	36
37	<u>Intercompany Transactions</u>	4,131,455		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,291,511	\$ 2,875,684	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		199,535	39
40	Mortgage Payable		1,109,250	40
41	Bonds Payable			41
42	Deferred Compensation		658,808	42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,967,593	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,291,511	\$ 4,843,278	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,681,285)	\$ 12,171,273	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,610,226	\$ 17,014,550	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,065,934)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,065,934)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	384,649	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)	\$ 384,649	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)	\$ (1,681,285)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Milestone Elmwood Heights

0024943

Report Period Beginning: 7/1/19

Ending:

6/30/20

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	\$ 9,369,108	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,369,108	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	191,414	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	10,497	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	20,790	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 222,701	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			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,591,809	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,419,001	31
32	Health Care	5,343,117	32
33	General Administration	1,703,905	33
	B. Capital Expense		
34	Ownership	204,057	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	537,080	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,207,160	40
41	Income before Income Taxes (line 30 minus line 40)**	384,649	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 384,649	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,739,149	44
45	Private Pay - Net Inpatient Revenue	629,959	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)	\$ 9,369,108	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	2,643	2,970	\$ 94,831	\$ 31.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,213	12,519	345,160	27.57	3
4	Licensed Practical Nurses	18,626	20,537	471,537	22.96	4
5	CNAs & Orderlies					5
6	CNA Trainees	14,737	14,737	169,332	11.49	6
7	Licensed Therapist	468	468	30,657	65.51	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,190	1,328	29,288	22.05	11
12	Dietician					12
13	Food Service Supervisor	860	1,019	28,741	28.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,098	13,449	167,982	12.49	15
16	Dishwashers					16
17	Maintenance Workers	8,504	9,400	163,946	17.44	17
18	Housekeepers	11,428	13,457	161,355	11.99	18
19	Laundry					19
20	Administrator	661	762	44,440	58.32	20
21	Assistant Administrator					21
22	Other Administrative	567	585	42,235	72.20	22
23	Office Manager	7,499	8,692	212,167	24.41	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	37,797	43,290	778,791	17.99	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	205,571	223,640	2,723,937	12.18	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	333,862	366,853	\$ 5,464,399 *	\$ 14.90	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		\$		35
36	Medical Director	144	36,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,875	61,865	10-3	38
39	Pharmacist Consultant	54	3,240	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	557	58,406	10-3	47
48					48
49	TOTAL (lines 35 - 48)	2,875	\$ 171,775		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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

no

(2) Are there any dues to nursing home associations included on the cost report?

no

If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization?

no

If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

no

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

yes

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

3-5 years

(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.

\$ 537,080

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

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

no

If YES, attach an explanation of the allocation.

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

yes

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

no

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ n/a

Has any meal income been offset against related costs?

Indicate the amount. \$

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

no

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

no

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100%

d. Have vehicle usage logs been maintained?

yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

yes

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

no

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

\$

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

yes

Firm Name: WIPFLI LLP

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

HFS 3745 (N-4-99)

IL478-2471

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	Director	Pension Accounting	McGladrey & Pullen
George Bass	Treasurer	Insurance	Country Ins. & Financial Group
Thomas Budd	Director	Financial	Illinois Bank & Trust
Carol Hartline	Director	Legal	Williams & McCarthy
Ben Holmstrom	Chairperson	Construction	William Charles Connstruction
Jack Kieckhefer	Director	Insurance	Kieckhefer & Nelson
Vickie Kieffer	Secretary	N/A	
Christine Kinsman	Director	N/A	
Tom Matus	Director	N/A	Mechanical Inc.
Becky Norwood	Director	Insurance	Gallagher Williams-Manny, Inc.
Cyrus Oates	Vice Chairperson	N/A	
Shawn Way	President & CEO	Administrative Services	
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	32	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.	18	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
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	8	Rockford	C.I.L.A. Services
Tulip	5	Rockford	C.I.L.A. Services
Packard	5	Rockford	C.I.L.A. Services
Apawamis	5	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	3,933.00
35	Equipment Rent	(3,933.00)
		<u>0</u>

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

30	Depreciation	2,812.00
36	Rent-Maintenance Building	(2,812.00)
		<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	\$384,649
	\$1,100,077 Related Organizational Net Income
Federal Form 990 Net Income	<u>\$1,484,726</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>
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
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	(A)	0.00	S/L-3 YR	0.00	(2,000.00)	20,611.50
06 Ford Eldorado	01/12/07	43,791.00		0.00	S/L-3 YR	0.00		43,791.00
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
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		0.00	S/L-3 YR	0.00		23,733.39
Plow for Ford Truck	08/23/12	4,338.00		0.00	S/L-3 YR	0.00		4,338.00
04 Ford Truck F250	10/05/12	6,419.00		0.00	S/L-3 YR	0.00		6,419.00
13 Ford E350	07/17/13	52,810.00		0.00	S/L-3 YR	0.00		52,810.00
14 Ford Taurus	05/13/14	12,456.27		0.00	S/L-3 YR	0.00		12,456.27
Plow	09/15/14	8,400.00		0.00	S/L-3 YR	0.00		8,400.00
15 Ford F250	11/03/14	26,003.00		0.00	S/L-3 YR	0.00		26,003.00
15 Ford Transit Connect	12/31/14	31,225.00		0.00	S/L-3 YR	0.00		31,225.00
17 Ford Taurus	02/28/17	21,759.00		4,230.82	S/L-3 YR	4,230.82		21,759.00
17 Ford Escape	09/26/17	25,575.15		8,525.04	S/L-3 YR	8,525.04		24,154.28
17 Dodge Caravan	10/09/17	25,117.15		8,372.40	S/L-3 YR	8,372.40		23,024.10
Lift	12/27/17	5,957.81		1,985.88	S/L-3 YR	1,985.88		4,964.70
2006 Ford Van	02/01/19	22,034.52		0.00	S/L-3 YR	0.00		22,034.52
19 Ford Van Raised Roof	04/09/19	50,086.00		16,695.36	S/L-3 YR	16,695.36		20,869.20
10 Keystone Sprinter Camper	04/23/20	11,702.50		975.21	S/L-3 YR	975.21		975.21
Less: A) Disposals		(20,611.50)						(20,611.50)
B) Gain on Sale of Fixed Assets						(2,000.00)		
C) Insurance Reimbursement						0.00		
TOTALS		<u>700,078.82</u>		<u>40,784.71</u>		<u>38,784.71</u>	<u>(2,000.00)</u>	<u>655,627.70</u>

Legal Fees
FY 2020

Williams & McCarthy

<u>Invoice Date</u>	<u>Check #</u>	<u>Amount</u>	<u>Description of Services</u>
11/20/19	207848	550.00	General Employment Matters

Milestone, Inc. - ELMWOOD HEIGHTS # 0024943
Schedule of In-Service Training
FY 2020

<u>INV DATE</u>	<u>AMOUNT</u>	<u>VENDOR</u>	<u>DESCRIPTION</u>
07/05/19	1,500.00	ARC	CPR & First Aid Training Materials
08/08/19	562.50	ARC	CPR & First Aid Training Materials
09/30/19	1,751.36	ARC	CPR & First Aid Training Materials
10/10/19	741.00	ARC	CPR & First Aid Training Materials
11/30/19	840.92	ARC	CPR & First Aid Training Materials
12/01/19	856.45	ARC	CPR & First Aid Training Materials
12/05/19	34.00	ARC	CPR & First Aid Training Materials
12/09/19	269.50	ARC	CPR & First Aid Training Materials
12/10/19	22.50	ARC	CPR & First Aid Training Materials
12/13/19	22.50	ARC	CPR & First Aid Training Materials
12/24/19	642.50	ARC	CPR & First Aid Training Materials
01/15/20	1,135.00	ARC	CPR & First Aid Training Materials
01/23/20	22.00	ARC	CPR & First Aid Training Materials
01/24/20	157.50	ARC	CPR & First Aid Training Materials
02/17/20	80.00	ARC	CPR & First Aid Training Materials
02/27/20	25.00	ARC	CPR & First Aid Training Materials
02/28/20	128.00	ARC	CPR & First Aid Training Materials
03/30/20	436.95	ARC	CPR & First Aid Training Materials
 TOTAL	 <u><u>\$ 9,227.68</u></u>		