

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0035386

Facility Name: Milestone Sun Valley

Address: 3351 Sun Valley 3351 Sun Valley Rockford 61103
Number City Zip Code

County: Winnebago

Telephone Number: (815) 654-6616 Fax # (815) 654-6616

HFS ID Number:

Date of Initial License for Current Owners:

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

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: Lisa Munson Telephone Number: (815) 654-6100 ext 2828
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7-1-24 to 6-30-25 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Lisa Munson

(Title) CFO

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

Facility Name & ID Number

Milestone Sun Valley

0035386

Report Period Beginning: 7-1-24

Ending: 6-30-25

III. STATISTICAL DATA

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

1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1		Skilled (SNF)		1
2		Skilled Pediatric (SNF/PED)		2
3		Intermediate (ICF)		3
4		Intermediate/DD		4
5		Sheltered Care (SC)		5
6	8	ICF/DD 16 or Less	8	2,920
7	8	TOTALS	8	2,920

B. Census-For the entire report period.

1	2	3	4	5	6	7	8	9		
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other		Total
				Medicaid Primary	Medicare Primary					
8	SNF								8	
9	SNF/PED								9	
10	ICF								10	
11	ICF/DD								11	
12	SC								12	
13	DD 16 OR LESS	2,415							2,415	
14	TOTALS	2,415							2,415	

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

82.71%

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

112 (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 ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/12/89

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

YES ☒ Date 6/12/89 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter certified beds.

number of certified beds

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☐ NO ☐

Tax Year: 6/30/25 Fiscal Year: 6/30/25

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

Facility Name & ID Number Milestone Sun Valley # 0035386 Report Period Beginning: 7-1-24 Ending: 6-30-25
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		768		768		768		768			1
2	Food Purchase		22,241		22,241		22,241		22,241			2
3	Housekeeping		3,374		3,374		3,374		3,374			3
4	Laundry		28		28		28		28			4
5	Heat and Other Utilities			14,875	14,875		14,875		14,875			5
6	Maintenance	16,121	16,738	4,118	36,977		36,977		36,977			6
7	Other (specify):* Security System Mobile Stops			3,000	3,000		3,000		3,000			7
8	TOTAL General Services	16,121	43,149	21,993	81,263		81,263		81,263			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	525,300	1,307	476	527,083		527,083		527,083			10
10a	Therapy											10a
11	Activities		2,715		2,715		2,715		2,715			11
12	Social Services	3,839			3,839		3,839		3,839			12
13	CNA Training											13
14	Program Transportation		2,325	4,196	6,521		6,521		6,521			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	529,139	6,347	4,672	540,158		540,158		540,158			16
	C. General Administration											
17	Administrative	7,331			7,331		7,331		7,331			17
18	Directors Fees											18
19	Professional Services			1,568	1,568		1,568		1,568			19
20	Dues, Fees, Subscriptions & Promotions			684	684		684		684			20
21	Clerical & General Office Expenses	17,503	5,128	6,991	29,622		29,622		29,622			21
22	Employee Benefits & Payroll Taxes			107,313	107,313		107,313		107,313			22
23	Inservice Training & Education			663	663		663		663			23
24	Travel and Seminar			370	370		370		370			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			11,103	11,103		11,103		11,103			26
27	Other (specify):*											27
28	TOTAL General Administration	24,834	5,128	128,692	158,654		158,654		158,654			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	570,094	54,624	155,357	780,075		780,075		780,075			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			5,524	5,524	453	5,977		5,977			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			264	264	(264)						35
36	Other (specify):* Alloc. Maint Bldg			189	189	(189)						36
37	TOTAL Ownership			5,977	5,977		5,977		5,977			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			33,648	33,648		33,648		33,648			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			33,648	33,648		33,648		33,648			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	570,094	54,624	194,982	819,700		819,700		819,700			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				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)	\$		\$	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))	\$		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	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			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

Summary A

6-30-25

[illegible]

Summary B

Facility Name & ID Number

0035386

Report Period Beginning:

7-1-24

Ending:

6-30-25

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

[illegible]

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 (continued)

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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	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 Sun Valley # 0035386 Report Period Beginning: 7-1-24 Ending: 6-30-25

VIII. ALLOCATION OF INDIRECT COSTS

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary Supplies	Days	6,999,360	30	\$ 1,860	\$	2,890,800	\$ 768	1
2	2	Food Purchase	Days	6,999,360	30	53,851		2,890,800	22,241	2
3	6	Maintenance Wages	Level of Care/Days	220,095	32	49,096	49,096	72,270	16,121	3
4	21	Clerical Wages	Level of Care/Days	6,999,360	35	42,379	42,379	2,890,800	17,503	4
5	21	Office Supplies	Level of Care/Days	6,999,360	35	9,302		2,890,800	3,842	5
6	21	Telephone,internet & cable	Level of Care/Days	6,999,360	35	16,927		2,890,800	6,991	6
7	22	Fringe Benefits	Wages	28,019,257	35	299,330		10,045,205	107,313	7
8	35	Rent-Computer	Level of Care/Days	6,999,360	35	639		2,890,800	264	8
9	36	Rent Maintenance Building	Level of Care/Days	6,999,360	35	458		2,890,800	189	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	TOTALS					\$ 473,842	\$ 91,475		\$ 175,232	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													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	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 2024 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 2025 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
Assessed Value from Real Estate Tax Bill:	2024		8		
Real Estate Tax Bill for Calendar Year:	2020		9		
	2021		10		
	2022		11		
	2023		12		
	2024		13		
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Milestone Sun Valley

COUNTY

Winnebago

FACILITY IDPH LICENSE NUMBER

0035386

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to providecopies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 6,400 B. General Construction Type: Exterior Brick/Cedar Frame wood 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. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases? yes

H. Are you presently operating under a sale and leaseback arrangement? no

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? no

J. 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.

K. 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:

1		2	3	4	
Use		Square Feet	Year Acquired	Cost	
1	project	33,000	1988	\$ 32,954	1
2					2
3	TOTALS	33,000		\$ 32,954	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	8		1989	1989	\$ 314,472	\$	30	\$	\$	314,472
5										
6										
7										
8										
	Improvement Type**									
9		SMOKE DETECTORS-AUDIO ENG #17		1997	3,050					3,050
10		CARPET-SHAW/LINDMAN'S CK#51451		1998	3,290					3,290
11		VERTICAL BLINDS-NANCY'S		1998	803					803
12		ROOF REPAIR ROOFMASTER CK# 95341		2005	7,125	327		327		7,125
13		FIRE PROTECTION MATERIALS-117105		2008	2,897					2,897
14		CARPET-ERIC JOHNSON #17		2008	6,016					6,016
15		CARPET-E.JOHNSON #17 2009		2009	9,071					9,071
16		CARPET-POGGIOLI CK#121092		2009	4,130					4,130
17		BLACKTOP Driveway-N.IL.BLCKTOP #122466		2009	7,933					7,933
18		A/C&FURNACE-RKFD HT&AIR 126502		2010	9,825	491		491		7,410
19		KITCHEN CABINETS		2011	5,303					5,303
20		Kitchen Remod-Remove&Install Cabints, Widen Door Opening, Relocate		2011	3,330					3,330
21		WATER HEATER-G W BERKHEIMER #189561		2014	3,712					3,712
22		SIDING-A ELDRIDGE CK #202858		2018	5,340	267		267		1,869
23		Carpet, living room, 2 bedrooms		2019	3,920					3,920
24		ROOF & GUTTERS STORM DAMAGE RESTORATION		2021	25,173	1,259		1,259		5,035
25		HVAC UNIT		2021	6,555	437		437		1,711
26		ROOF & GUTTERS STORM DAMAGE RESTORATION		2022	9,553	478		478		1,393
27		Deck		2022	15,248	1,016		1,016		2,880
28		Gas pipe to Generator		2023	5,223	348		348		754
29		Generator		2023	6,200	620		620		1,499
30		Fire Alarm Control Panel		2024	4,220	281		281		281
31		Allocated Maintenance Building				189		189		
32										
33										
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$462,388	\$5,713		\$5,713	\$	\$397,883	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	24,736				5 years	24,736	73
74	Central Office Computer		264	264				74
75	TOTALS	\$ 24,736	\$ 264	\$ 264	\$		\$ 24,736	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	patient care	15 Ford Transit Connect	2014	\$ 32,468	\$	\$	\$	3	\$ 32,468	76
77										77
78										78
79										79
80	TOTALS			\$ 32,468	\$	\$	\$		\$ 32,468	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)	\$ 552,546	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 5,977	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 5,977	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 455,087	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: \$ 1,287 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.

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

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

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 8,757,249	1
2	Cash-Patient Deposits	15,081	493,396	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	59,933	3,645,960	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,725,702	5
6	Prepaid Insurance		340,006	6
7	Other Prepaid Expenses		32,920	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		4,251	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 75,014	\$ 15,999,484	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,954	1,608,882	13
14	Buildings, at Historical Cost	462,388	23,404,051	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	57,204	5,447,933	16
17	Accumulated Depreciation (book methods)	(455,088)	(21,620,079)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		1,259,726	21
22	Other Long-Term Assets (spe Right of Use Assets		364,294	22
23	Other(specify): Deferred Comp		491,848	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 97,458	\$ 10,956,655	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 172,472	\$ 26,956,139	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$ 299,392	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,081	493,396	28
29	Short-Term Notes Payable		5,416	29
30	Accrued Salaries Payable		1,990,011	30
31	Accrued Taxes Payable (excluding real estate taxes)		115,897	31
32	Accrued Real Estate Taxes(Sch.IX-B)		4,306	32
33	Accrued Interest Payable		53	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Pension,Health plan		671,959	36
37	Intercompany transactions	416,301		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 431,382	\$ 3,580,430	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Accrued Severance Pay,457(B)		541,679	43
44	Lease		256,242	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 797,921	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 431,382	\$ 4,378,351	46
47	TOTAL EQUITY(page 18, line 24)	\$ (258,910)	\$ 22,577,788	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 172,472	\$ 26,956,139	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (51,152)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (51,152)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(207,758)	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)	\$ (207,758)	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)	\$ (258,910)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Milestone Sun Valley

0035386

Report Period Beginning:

7-1-24

Ending:

6-30-25

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	\$ 611,942	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 611,942	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		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		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	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)	\$ 611,942	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	81,263	31
32	Health Care	540,158	32
33	General Administration	158,654	33
	B. Capital Expense		
34	Ownership	5,977	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	33,648	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 819,700	40
41	Income before Income Taxes (line 30 minus line 40)**	(207,758)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (207,758)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 518,780.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	93,162.00	48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	56

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	481	579	\$ 27,800	\$ 48.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	30	30	2,351	78.37	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	99	116	3,839	33.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	514	592	16,121	27.23	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	60	73	3,371	46.18	20
21	Assistant Administrator					21
22	Other Administrative	40	41	3,960	96.59	22
23	Office Manager					23
24	Clerical	423	495	17,503	35.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	4,263	4,792	142,035	29.64	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	12,795	14,290	353,114	24.71	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,705	21,008	\$ 570,094 *	\$ 27.14	34

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				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) dental	9	476	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	9	\$ 476		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

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberMilestone Sun Valley# 0035386Report Period Beginning:7-1-24Ending:6-30-25Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Administrators	Administrator		\$ 3,371
CEO	Administrative		3,960
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 7,331

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
Newport Group	Pension Plan	\$ 556
Anderson Computer,Perryman, I P c	Computer/Programming	156
Williams McCarthy	General Employment Matters	160
EC3 Compnay	Administrative Consultant	30
Wipfli LLP	Audit	666
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 1,568

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 5,608	
Unemployment Compensation Insurance	214	
FICA Taxes	42,725	
Employee Health Insurance	47,390	
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Other Employee Benefits	1,803	
Employee Physical Exams	602	
Penison	6,879	
Disability Insurance	1,833	
Group Life Insurance	259	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 107,313

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	42	
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks		
Association Dues (total from pg 22, #4)	300	
Fees	320	
Subscriptions,Books & Periodicals	22	
Less: Public Relations Expense	()	
PAC and Lobbying payments	()	
All non-allowable advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 684

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	370
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 370

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? _____
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------|
| _____ | _____ |
| _____ | _____ |
| Other, please specify The Institute on Public Policy for People w | 300 |
| | 300 |
| | Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------|
| _____ | _____ |
| _____ | _____ |
| Other, please specify The Institute on Public Policy for People with Disabilities | |
| _____ | _____ |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|--------------|
| _____ | _____ |
| _____ | _____ |
| Other, please specify The Institute on Public Policy for People w | 300 |
| _____ | _____ |
| | 300 |
| | Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ n/a Line _____
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 33,648
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) 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. \$ _____
- (12) 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. \$ _____
- (13) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: WIPFLI LLP
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (15) 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	Director	Construction	William Charles Connstruction
Thomas Budd	Director	Financial	Illinois Bank & Trust
Carol Hartline	Director	Legal	Williams & McCarthy
Ben Holmstrom	Director	Construction	William Charles Connstruction
Jack Kieckhefer	Director	N/A	
Vickie Kieffer	Director	N/A	
Derek Kiley	Secretary	N/A	
Christine Kinsman	Director	N/A	
Tom Matus	Chairperson	Construction	Helm Group
Todd Stern	Director	N/A	
Dan VanSistine	Director	N/A	
Lynn Williams	Vice Chairperson	N/A	
William Grahn	President & CEO	Administrative Services	

SCHEDULE VII-A: RELATED PARTIES

	RESIDENTIAL		TYPE OF
<u>MILESTONE, INC.</u>	<u>BEDS</u>	<u>CITY</u>	<u>BUSINESS</u>
Central Office	N/A	Rockford	Central Office
Elmwood Heights	67	Rockford	ICF/MR-SLC
Elmwood East	12	Rockford	ICF/DD<16 & Fewer
Searles	8	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	8	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.	16	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
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	4	Rockford	C.I.L.A. Services on 3-1-25 now a 4 bed home was 5
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

Net Income or Loss ForYear

Page 19, Line 41 (\$207,758)

Related Organizations Net \$1,837,367

Consolidated Earnings 1,629,609

RECLASSIFICATION - SCHEDULE V. COLUMN 5

SCHEDULE V		
<u>Line #</u>	<u>Title</u>	<u>Amount</u>
30	Depreciation	264.00
35	Equipment Rent	<u>(264.00)</u>
		<u>0</u>

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

30	Depreciation	189.00
36	Rent-Maintenance Building	<u>(189.00)</u>
		<u>0</u>

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

-------	--	--