

		FOR BHF USE						

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

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

<p>I. IDPH License ID Number: <u>0027334</u></p> <p>Facility Name: <u>Milestone-Elmwood East</u></p> <p>Address: <u>2642 Elmwood Road</u> <u>Rockford</u> <u>61103</u> Number City Zip Code</p> <p>County: <u>Winnebago</u></p> <p>Telephone Number: <u>(815) 877-7001</u> Fax # <u>(815) 654-6445</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/14/82</u></p> <p>Type of Ownership:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><input checked="checked" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%;"><input type="checkbox"/> PROPRIETARY</td> <td style="width: 33%;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="padding-left: 20px;"><input checked="checked" type="checkbox"/> Charitable Corp.</td> <td style="padding-left: 20px;"><input type="checkbox"/> Individual</td> <td style="padding-left: 20px;"><input type="checkbox"/> State</td> </tr> <tr> <td style="padding-left: 20px;"><input type="checkbox"/> Trust</td> <td style="padding-left: 20px;"><input type="checkbox"/> Partnership</td> <td style="padding-left: 20px;"><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501(c)3</u></td> <td style="padding-left: 20px;"><input type="checkbox"/> Corporation</td> <td style="padding-left: 20px;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td style="padding-left: 20px;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="padding-left: 20px;">_____</td> </tr> <tr> <td></td> <td style="padding-left: 20px;"><input type="checkbox"/> Limited Liability Co.</td> <td style="padding-left: 20px;">_____</td> </tr> <tr> <td></td> <td style="padding-left: 20px;"><input type="checkbox"/> Trust</td> <td style="padding-left: 20px;">_____</td> </tr> <tr> <td></td> <td style="padding-left: 20px;"><input type="checkbox"/> Other</td> <td style="padding-left: 20px;">_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Hugh W. Lippitt</u> Telephone Number: <u>(815) 639-2806</u> Email Address: _____</p>	<input checked="checked" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="checked" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501(c)3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/11</u> to <u>06/30/12</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.</p> <p style="text-align: center;">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border: 1px solid black; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Hugh W. Lippitt</u> (Title) <u>Senior Vice President & C.F.O.</u></td> </tr> <tr> <td style="border: 1px solid black; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p style="text-align: right;">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Hugh W. Lippitt</u> (Title) <u>Senior Vice President & C.F.O.</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()
<input checked="checked" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input checked="checked" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
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IRS Exemption Code <u>501(c)3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																											
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Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Hugh W. Lippitt</u> (Title) <u>Senior Vice President & C.F.O.</u>																												
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()																												

Facility Name & ID Number Milestone-Elmwood East

0027334 Report Period Beginning: 07/01/11 Ending: 06/30/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	12	ICF/DD 16 or Less	12	4,392	6
7	12	TOTALS	12	4,392	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,256			4,256	13
14	TOTALS	4,256			4,256	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.90%

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

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

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 05/01/80

J. Was the facility purchased or leased after January 1, 1978?
YES Date 02/06/81 NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/12 Fiscal Year: 06/30/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	18,319	2,695	958	21,972		21,972	21,972			1
2	Food Purchase		42,244		42,244		42,244	42,244			2
3	Housekeeping	10,511			10,511		10,511	10,511			3
4	Laundry		252		252		252	252			4
5	Heat and Other Utilities			9,253	9,253		9,253	9,253			5
6	Maintenance	15,504	9,887	1,748	27,139		27,139	27,139			6
7	Other (specify):* Maint. Fee			9,027	9,027		9,027	(9,027)			7
8	TOTAL General Services	44,334	55,078	20,986	120,398		120,398	(9,027)	111,371		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	281,376	2,778	1,752	285,906		285,906	285,906			10
10a	Therapy										10a
11	Activities		2,692		2,692		2,692	2,692			11
12	Social Services	14,068			14,068		14,068	14,068			12
13	CNA Training										13
14	Program Transportation		2,216	230	2,446		2,446	2,446			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	295,444	7,686	1,982	305,112		305,112	305,112			16
	C. General Administration										
17	Administrative	13,594			13,594		13,594	13,594			17
18	Directors Fees										18
19	Professional Services			5,377	5,377		5,377	(1,296)	4,081		19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses	26,645	4,985	4,204	35,834		35,834	35,834			21
22	Employee Benefits & Payroll Taxes			84,847	84,847		84,847	84,847			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,855	3,855		3,855	3,855			26
27	Other (specify):* Management Fee			4,032	4,032		4,032	(4,032)			27
28	TOTAL General Administration	40,239	4,985	102,315	147,539		147,539	(5,328)	142,211		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	380,017	67,749	125,283	573,049		573,049	(14,355)	558,694		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 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	
	D. Ownership											
30	Depreciation			16,375	16,375	799	17,174	135	17,309			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,209	11,209		11,209	133	11,342			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			28,701	28,701		28,701	(28,701)				34
35	Rent-Equipment & Vehicles			496	496	(496)						35
36	Other (specify):* Alloc. Maint. Bldg			303	303	(303)						36
37	TOTAL Ownership			57,084	57,084		57,084	(28,433)	28,651			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			34,384	34,384		34,384		34,384			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			34,384	34,384		34,384		34,384			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	380,017	67,749	216,751	664,517		664,517	(42,788)	621,729			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(28,701)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	135	30		9
10	Interest and Other Investment Income	133	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see page 5A	(14,355)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (42,788)		\$	30

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	2	
		Amount	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)	\$ 671	32	36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (42,117)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY						
48		49		50		51
						52

Milestone-Elmwood East

ID# 0027334

Report Period Beginning: 07/01/11

Ending: 06/30/12

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Management Fee	\$ (4,032)	27	1
2	Maintenance Fee	(9,027)	7	2
3	Bookkeeping/Computer Fee	(1,296)	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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		(14,355)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Milestone-Elmwood East

0027334

Report Period Beginning:

07/01/11

Ending:

06/30/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	(9,027)	0	0	0	0	0	0	0	0	0	0	(9,027)	7
8	TOTAL General Services	(9,027)	0	0	0	0	0	0	0	0	0	0	(9,027)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,296)	0	0	0	0	0	0	0	0	0	0	(1,296)	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):*	(4,032)	0	0	0	0	0	0	0	0	0	0	(4,032)	27
28	TOTAL General Administration	(5,328)	0	0	0	0	0	0	0	0	0	0	(5,328)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,355)	0	0	0	0	0	0	0	0	0	0	(14,355)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Milestone-Elmwood East

0027334

Report Period Beginning:

07/01/11 Ending:

06/30/12

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	135	0	0	0	0	0	0	0	0	0	0	135	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	133	0	0	0	0	0	0	0	0	0	0	133	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(28,701)	0	0	0	0	0	0	0	0	0	0	(28,701)	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	(28,433)	0	0	0	0	0	0	0	0	0	0	(28,433)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(42,788)	0	0	0	0	0	0	0	0	0	0	(42,788)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see pages 24 & 25						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Milestone-Elmwood East # 0027334 Report Period Beginning: 07/01/11 Ending: 06/30/12

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 East

0027334

Report Period Beginning:

07/01/11

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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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary Wages	Days	57,670	4	\$ 241,191	\$ 241,191	4,380	\$ 18,318	1
2	1	Dietary Supplies	Days	117,530	33	72,151	4,380	4,380	2,689	2
3	2	Food Purchase	Days	117,530	33	1,133,632	4,380	4,380	42,247	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	167,296	167,296	8,760	10,511	4
5	6	Maintenance Wages	Level of Care/Days	289,810	34	512,718	512,718	8,760	15,498	5
6	21	Clerical Wages	Level of Care/Days	9,149,760	36	447,755	447,755	315,360	15,433	6
7	21	Office Supplies	Level of Care/Days	9,149,760	36	144,574		315,360	4,983	7
8	21	Telephone	Level of Care/Days	9,149,760	36	122,179		315,360	4,211	8
9	22	Fringe Benefits	Wages	16,185,858	41	365,673		380,017	8,585	9
10	35	Rent-Computer	Level of Care/Days	9,149,760	36	14,575		315,360	502	10
11	36	Rent Maintenance Bldg	Level of Care/Days	9,149,760	36	8,774		315,360	302	11
12										12
13										13
14		see addendum A								14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,230,518	\$ 1,368,960		\$ 123,279	25

Facility Name & ID Number

Milestone-Elmwood East

0027334

Report Period Beginning:

07/01/11

Ending:

06/30/12

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1	U.S. Dept. of HUD		X	Mortgage		5/8/80	\$ 288,847	\$ 142,337	10/1/20	7.6250	\$ 10,600	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Rockford Bank & Trust		X	Line of Credit		11/30/11	2,500,000		11/30/12	7.2500	609	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 2,788,847	\$ 142,337			\$ 11,209	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,788,847	\$ 142,337			\$ 11,209	15						

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1. Real Estate Tax accrual used on 2011 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 2012 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:	2007 _____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$ _____</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> <td style="text-align: center;">16</td> </tr> </table>			FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2011 \$ _____	13	14	PLUS APPEAL COST FROM LINE 5 \$ _____	14	15	LESS REFUND FROM LINE 6 \$ _____	15	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2011 \$ _____	13																	
14	PLUS APPEAL COST FROM LINE 5 \$ _____	14																	
15	LESS REFUND FROM LINE 6 \$ _____	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16																	
	2008 _____	9																	
	2009 _____	10																	
	2010 _____	11																	
	2011 _____	12																	

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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Milestone-Elmwood East COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0027334

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

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

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,565 B. General Construction Type: Exterior Brick Frame 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Project</u>	<u>64,925</u>	<u>1979</u>	<u>\$ 11,726</u>	1
2					2
3	TOTALS	64,925		\$ 11,726	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	12	1980	1980	\$ 277,049	\$ 2,125	50	\$ 2,260	\$ 135	\$ 189,392	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Replace patio door		1995	2,688		15			2,688	9
10	Fire Alarm System		1998	1,550	78	20	78		1,118	10
11	Windows		1999	8,616	574	15	574		7,563	11
12	Roof Repair		1999	4,540	227	20	227		2,876	12
13	Floor Coverings		1999	5,759		5			5,759	13
14	Carpet		2001	2,527		5			2,527	14
15	Sidewalk Repair		2001	2,695	135	20	135		1,494	15
16	Landscaping		1992	3,830		10			3,830	16
17	Water Heater		1993	1,526		10			1,526	17
18	Blacktop		1994	7,070		15			7,070	18
19	Cement		1994	1,950	98	20	98		1,748	19
20	Water Line		1997	4,890	326	15	326		4,755	20
21	Carpet		2001	2,600		10			2,600	21
22	Water Heater		2003	2,729	273	10	273		2,524	22
23	Replace cabinets and doors in bathrooms		2003	2,784	186	15	186		1,640	23
24	Bathroom Countertop		2003	3,742	249	15	249		2,204	24
25	Cabinets		2003	2,064	138	15	138		1,193	25
26	Counter Top		2003	2,413	161	15	161		1,393	26
27	Sidewalk Repair		2004	7,060	282	25	282		1,976	27
28	Furnace		2006	2,695	135	20	135		831	28
29	Carpet		2008	6,016	1,203	5	1,203		4,512	29
30	Carpet		2009	8,044	1,608	5	1,608		4,290	30
31	Bathroom Remodel/new walk in shower, valve, grab bars, drywall repair		2012	4,470		15				31
32	Allocated Maintenance Building				303		303			32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Milestone-Elmwood East

0027334

Report Period Beginning:

07/01/11

Ending:

06/30/12

XI. OWNERSHIP COSTS (continued)

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

	1	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)		\$ 369,307	\$ 8,101		\$ 8,236	\$ 135	\$ 255,509	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,774	\$ 377	\$ 377	\$		\$ 2,264	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	52,996						73
74	Central Office Computer		496	496				74
75	TOTALS	\$ 56,770	\$ 873	\$ 873	\$		\$ 2,264	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	2007 Ford Van	2007	\$ 22,229	\$	\$	\$	3	\$ 22,229	76
77	Patient Care	2011 Ford Van	2010	24,600	8,200	8,200		3	15,033	77
78										78
79										79
80	TOTALS			\$ 46,829	\$ 8,200	\$ 8,200	\$		\$ 37,262	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)	\$ 484,632	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,174	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,309	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 135	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 295,035	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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

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

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* 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.

Facility Name & ID Number Milestone-Elmwood East # 0027334 Report Period Beginning: 07/01/11 Ending: 06/30/12
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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.

Facility Name & ID Number Milestone-Elmwood East

0027334

Report Period Beginning: 07/01/11

Ending:

06/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/12 (last day of reporting year)

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	\$ 68,980	\$ 1,600,402	1
2	Cash-Patient Deposits	9,144	215,108	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	156,855	4,256,272	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		2,238	6
7	Other Prepaid Expenses		17,900	7
8	Accounts Receivable (owners or related parties)		151,217	8
9	Other(specify): <u>Other A/R</u>	232	19,628	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 235,211	\$ 6,262,765	10
B. Long-Term Assets				
11	Long-Term Notes Receivable		132,392	11
12	Long-Term Investments			12
13	Land	11,726	1,566,296	13
14	Buildings, at Historical Cost	352,811	20,229,924	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	103,599	5,386,720	16
17	Accumulated Depreciation (book methods)	(382,000)	(16,642,083)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		110,273	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(110,273)	20
21	Restricted Funds		1,186,000	21
22	Other Long-Term Assets (spec Escrow & loan fees)		338,482	22
23	Other(specify): <u>Value Life Ins.&Const.in prog</u>		268,196	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 86,136	\$ 12,465,927	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 321,347	\$ 18,728,692	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 651	\$ 478,709	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,144	215,108	28
29	Short-Term Notes Payable		1,200,000	29
30	Accrued Salaries Payable		1,002,142	30
31	Accrued Taxes Payable (excluding real estate taxes)		101,618	31
32	Accrued Real Estate Taxes(Sch.IX-B)		90	32
33	Accrued Interest Payable	851	61,443	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Pension, Wrkmns Comp, SecDep, etc.</u>	2,316	521,005	36
37	<u>Intercompany A/P</u>	(205,065)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (192,103)	\$ 3,580,115	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	133,863	2,545,128	40
41	Bonds Payable		2,105,000	41
42	Deferred Compensation		318,696	42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 133,863	\$ 4,968,824	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (58,240)	\$ 8,548,939	46
47	TOTAL EQUITY(page 18, line 24)	\$ 379,586	\$ 10,179,753	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 321,346	\$ 18,728,692	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 401,311	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 401,311	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(21,725)	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)	\$ (21,725)	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)	\$ 379,586	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 564,838	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 564,838	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	34,765	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	28,701	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)	\$ 63,466	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	133	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 133	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management & Maintenance Fee	14,355	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,355	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 642,792	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	120,398	31
32	Health Care	305,113	32
33	General Administration	147,538	33
B. Capital Expense			
34	Ownership	57,084	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	34,384	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 664,517	40
41	Income before Income Taxes (line 30 minus line 40)**	(21,725)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (21,725)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 476,713	44
45	Private Pay - Net Inpatient Revenue	88,125	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)	\$ 564,838	49

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

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

*** See 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.

Facility Name & ID Number Milestone-Elmwood East

0027334

Report Period Beginning:

07/01/11

Ending:

06/30/12

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	697	797	19,372	24.31	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	708	785	14,068	17.92	11
12	Dietician					12
13	Food Service Supervisor	94	118	3,059	25.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,343	1,493	15,260	10.22	15
16	Dishwashers					16
17	Maintenance Workers	873	1,009	15,504	15.37	17
18	Housekeepers	908	1,052	10,511	9.99	18
19	Laundry					19
20	Administrator	203	235	9,053	38.52	20
21	Assistant Administrator					21
22	Other Administrative	58	62	4,541	73.24	22
23	Office Manager	615	715	15,429	21.58	23
24	Clerical	776	885	11,216	12.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,060	2,330	39,799	17.08	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	19,743	21,243	222,205	10.46	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	28,078	30,724	\$ 380,017 *	\$ 12.37	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	25	\$ 958	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental</u>	35	1,752	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	60	\$ 2,710		49

C. CONTRACT NURSES

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

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

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

Facility Name & ID Number Milestone-Elmwood East

0027334

Report Period Beginning: 07/01/11

Ending: 06/30/12

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? n/a
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
Milestone, Inc. - Elmwood East C.L.F. License #200321
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 34,384
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? yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
- g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Wipfli LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? n/a
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 FACILIT</u>	<u>OWNERSHIP INTEREST IN</u>
Patrick Agnew	Director	Legal	Agnew Law Offices
Ronald Alden	Vice Chairperson	Pension Accounting	McGladrey & Pullen
George Bass	Treasurer	Insurance	Country Ins. & Financial Group
Thomas Budd	Chairperson	Financial	Rockford Bank & Trust
Alan W. Bjork	Secretary	N/A	
Lyla DeVerdi	Director	N/A	
Judd Gastel	Director	N/A	
Peggy Hanson	Director	N/A	
Carol Hartline	Director	Legal	Williams & McCarthy
Jack Kieckhefer	Director	Insurance	Kieckhefer & Nelson
Cyrus Oates	Director	N/A	
Randy L. Cooper	Vice Chairperson	Insurance	Williams Manny
Ben Holmstrom	Director	Construction	William Charles Connstruction
Shawn Way	President & CEO	Administrative Services	Rockford Bank & Trust
Audrey Wickstrand	Director	N/A	

SCHEDULE VII-A: RELATED PARTIES

<u>MILESTONE, INC.</u>	<u>RESIDENTIAL BEDS</u>	<u>CITY</u>	<u>TYPE OF BUSINESS</u>
Central Office	N/A	Rockford	Central Office
Elmwood Heights	84	Rockford	ICF/MR-SLC
Elmwood East	12	Rockford	ICF/DD<16 & Fewer
Searles	12	Rockford	ICF/DD<16 & Fewer
Sun Valley	8	Rockford	ICF/DD<16 & Fewer
Applewood	8	Loves Park	C.R.A. - Waiver/C.I.L.A. Services
Orchard	8	Rockford	C.R.A. - Waiver/C.I.L.A. Services
Training Center	N/A	Rockford	Developmental Training
Industries	N/A	Loves Park	Developmental Training
RocVale Childrens Home	50	Rockford	Children's Group Home DD
Shattuck	5	Rockford	C.I.L.A. Services
Eggleston	5	Rockford	C.I.L.A. Services
Dierks	8	Rockford	C.I.L.A. Services
Geneva	5	Rockford	C.I.L.A. Services
C.I.L.A.	22	Rockford	C.I.L.A. Services
South Mulford	9	Rockford	C.I.L.A. Services
Park Terrace	7	Rockford	C.I.L.A. Services
Windcloud	5	Rockford	C.I.L.A. Services
Prospect	5	Rockford	C.I.L.A. Services
Hanford	5	Rockford	C.I.L.A. Services
Rural	5	Rockford	C.I.L.A. Services
Flintridge	5	Rockford	C.I.L.A. Services
Old Golf	8	Loves Park	C.I.L.A. Services
Creekside	5	Rockford	C.I.L.A. Services
Hermitage	5	Rockford	C.I.L.A. Services
Javelin II	5	Rockford	C.I.L.A. Services
Windpoint	5	Rockford	C.I.L.A. Services
Weymouth	5	Rockford	C.I.L.A. Services
Fleetwood	5	Rockford	C.I.L.A. Services
Stornway	5	Rockford	C.I.L.A. Services
Shiloh	6	Rockford	C.I.L.A. Services
Black Oak	5	Rockford	C.I.L.A. Services
Donna Drive	8	Rockford	C.I.L.A. Services
Respite Services	N/A	Rockford	Respite Services
Sawgrass	6	Rockford	C.I.L.A. Services

Crested Butte	6	Rockford	C.I.L.A. Services
Dental Program	N/A	Rockford	Dental Services
Thyme	7	Rockford	C.I.L.A. Services
Tulip	5	Rockford	C.I.L.A. Services
Packard	5	Rockford	C.I.L.A. Services
Southbridge	5	Rockford	C.I.L.A. Services
HUD Project #071-EH003	N/A	Rockford	Housing
HUD Project #071-EH059	N/A	Rockford	Housing
HUD Project #071-EH178	N/A	Rockford	Housing
HUD Project #071-HD160	N/A	Rockford	Housing
Bingo	N/A	Rockford	Bingo

Interest Expense

Mortgage loan with the U.S. Department of Housing and Urban Development on the Strathmoor and Elmwood East buildings has been restated to conform with the I.D.P.A. field audit by Bercoom, Weiner, Glick and Brook for FY 1984. The book method valued each building at 50% of the mortgage. The field audit valued the Elmwood East portion at 53.1652% of the total.

	<u>TOTAL</u>	<u>50% on Books</u>	<u>53.1652% per Audit</u>	<u>Adjustment</u>
Original Loan Balance	543,300	271,650	288,847	
Current Balance	267,726	133,863	142,337	
Current Period Interest	21,199	10,600	11,270	671

RECLASSIFICATION - SCHEDULE V. COLUMN 5

SCHEDULE
V

<u>Line #</u>	<u>Title</u>	<u>Amount</u>
30	Depreciation	496.00
35	Equipment Rent	<u>(496.00)</u>
		<u>0</u>

To reclassify rental of Computer from Milestone, Inc. Central Office.		
30	Depreciation	303.00
36	Rent-Maintenance Building	<u>(303.00)</u>
		<u>0</u>

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

Schedule of Federal Form 990 Reconciliation

Page 19, Line 41	(\$21,725)
Related Organizations Net Income	(8,078)
Federal Form 990 Net Income	<u>(\$29,803)</u>

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

<u>Page</u>	<u>Line</u>	<u>Column</u>	<u>Description</u>	<u>DR / (CR)</u>
3	7	7	Maintenance Fee Expense	(9,027)
3	27	7	Management Fee Expense	(4,032)
3	19	7	Bookkeeping/Computer Fee	(1,296)
19	29	1	Mgmt/Maint/Bookkeeping Fee Revenue	14,355
4	34	7	Rent Expense - Facility	(28,701)
19	16	1	Rent Revenue - Facility	28,701

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

<u>Page</u>	<u>Line</u>	<u>Column</u>	<u>Description</u>	<u>DR / (CR)</u>
4	32	7	Interest Expense	(133)
19	25	1	Interest Income	133

(see also page 5, line 10, column 1)

**ADDENDUM
A**