

Facility Name & ID Number Milestone-Elmwood Heights

0024943 Report Period Beginning: 07/01/16 Ending: 06/30/17

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	84	Intermediate/DD	84	30,660	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	29,846			29,846	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,846			29,846	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.35%

D. How many bed reserve days during this year were paid by the Department?
21 (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 09/04/79

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ 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: 06/30/17 Fiscal Year: 06/30/17

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

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/16 Ending: 06/30/17

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	136,108	20,482	480	157,070		157,070	157,070			1
2	Food Purchase		323,567		323,567		323,567	323,567			2
3	Housekeeping	114,269	134,030	6,728	255,027		255,027	255,027			3
4	Laundry		26,824		26,824		26,824	26,824			4
5	Heat and Other Utilities			173,924	173,924		173,924	173,924			5
6	Maintenance	121,695	192,742	14,380	328,817		328,817	328,817			6
7	Other (specify):*										7
8	TOTAL General Services	372,072	697,645	195,512	1,265,229		1,265,229	1,265,229			8
	B. Health Care and Programs										
9	Medical Director			27,000	27,000		27,000	27,000			9
10	Nursing and Medical Records	2,759,534	295,188	127,448	3,182,170		3,182,170	3,182,170			10
10a	Therapy										10a
11	Activities		29,311		29,311		29,311	29,311			11
12	Social Services										12
13	CNA Training	178,574			178,574		178,574	178,574			13
14	Program Transportation		25,299	4,898	30,197		30,197	30,197			14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,938,108	349,798	159,346	3,447,252		3,447,252	3,447,252			16
	C. General Administration										
17	Administrative	101,969			101,969		101,969	101,969			17
18	Directors Fees										18
19	Professional Services			16,610	16,610		16,610	16,610			19
20	Dues, Fees, Subscriptions & Promotions			13,087	13,087		13,087	13,087			20
21	Clerical & General Office Expenses	155,155	36,663	42,439	234,257		234,257	234,257			21
22	Employee Benefits & Payroll Taxes			1,013,412	1,013,412		1,013,412	1,013,412			22
23	Inservice Training & Education			5,324	5,324		5,324	5,324			23
24	Travel and Seminar			3,682	3,682		3,682	3,682			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			63,270	63,270		63,270	63,270			26
27	Other (specify):*										27
28	TOTAL General Administration	257,124	36,663	1,157,824	1,451,611		1,451,611	1,451,611			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,567,304	1,084,106	1,512,682	6,164,092		6,164,092	6,164,092			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			165,133	165,133	5,646	170,779	(1,800)	168,979			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			953	953		953		953			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,533	9,533	(3,292)	6,241		6,241			35
36	Other (specify):* Alloc. Maint Bldg			2,354	2,354	(2,354)						36
37	TOTAL Ownership			177,973	177,973		177,973	(1,800)	176,173			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			333,472	333,472		333,472		333,472			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			333,472	333,472		333,472		333,472			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,567,304	1,084,106	2,024,127	6,675,537		6,675,537	(1,800)	6,673,737			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,800)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,800)		\$	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)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,800)		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	

Milestone-Elmwood Heights

ID# 0024943

Report Period Beginning: 07/01/16

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Milestone-Elmwood Heights

0024943

Report Period Beginning:

07/01/16

Ending:

06/30/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Milestone-Elmwood Heights # 0024943 Report Period Beginning: 07/01/16 Ending: 06/30/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(1,800)	0	0	0	0	0	0	0	0	0	0	(1,800) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(1,800)	0	0	0	0	0	0	0	0	0	0	(1,800) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,800)	0	0	0	0	0	0	0	0	0	0	(1,800) 45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
see pages 23 & 24						

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

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

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

Facility Name & ID Number

Milestone-Elmwood Heights

0024943

Report Period Beginning:

07/01/16

Ending:

06/30/17

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 Heights # 0024943 Report Period Beginning: 07/01/16 Ending: 06/30/17

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Milestone-Elmwood Heights

0024943

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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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary Wages	Days	57,670	4	\$ 256,012	\$ 256,012	30,660	\$ 136,108	1
2	1	Dietary Supplies	Days	118,990	34	79,491		30,660	20,482	2
3	2	Food Purchase	Days	118,990	34	1,255,747		30,660	323,567	3
4	3	Housekeeping Wages	Level of Care/Days	139,430	6	173,218	173,218	91,980	114,269	4
5	6	Maintenance Wages	Level of Care/Days	298,570	36	395,026	395,026	91,980	121,695	5
6	21	Clerical Wages	Level of Care/Days	9,360,000	38	698,837	698,837	2,207,520	164,818	6
7	21	Office Supplies	Level of Care/Days	9,360,000	38	155,453		2,207,520	36,663	7
8	21	Telephone	Level of Care/Days	9,360,000	38	179,945		2,207,520	42,439	8
9	22	Fringe Benefits	Wages	16,838,800	42	4,781,570		3,567,304	1,012,977	9
10	35	Rent-Computer	Level of Care/Days	9,360,000	38	13,959		2,207,520	3,292	10
11	36	Rent Maintenance Building	Level of Care/Days	9,360,000	38	9,981		2,207,520	2,354	11
12										12
13										13
14		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					\$ 7,999,239	\$ 1,523,093		\$ 1,978,664	25

Facility Name & ID Number

Milestone-Elmwood Heights

0024943

Report Period Beginning:

07/01/16

Ending:

06/30/17

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																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Rockford Bank & Trust		X	Line of Credit	N/A	2/28/17	2,500,000		2/28/18	Floating	674									
7	Rockford Bank & Trust		X	Line of Credit-Vehicles	N/A	5/7/13	240,000		12/7/16	Floating	279									
8																				
9	TOTAL Facility Related						\$ 2,740,000	\$			\$ 953									
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related						\$	\$			\$									
15	TOTALS (line 9+line14)						\$ 2,740,000	\$			\$ 953									

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 2016 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 2017 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:

2012	_____	8
2013	_____	9
2014	_____	10
2015	_____	11
2016	_____	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$ _____	13
14	PLUS APPEAL COST FROM LINE 5	\$ _____	14
15	LESS REFUND FROM LINE 6	\$ _____	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Milestone-Elmwood Heights COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0024943

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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.**

Facility Name & ID Number Milestone-Elmwood Heights

0024943

Report Period Beginning:

07/01/16

Ending:

06/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,570 B. General Construction Type: Exterior Brick Frame cement block Number of Stories one

C. Does the Operating Entity? [X] (a) Own the Facility [] (b) Rent from a Related Organization. [] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [] (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Empty lines for listing other business entities.

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

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Project, Recreational Land, and TOTALS.

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Milestone-Elmwood Heights

0024943

Report Period Beginning:

07/01/16

Ending:

06/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Furnace	1994	\$ 40,882	\$	20	\$	\$	\$ 40,882	37
38	Telephones	1994	3,111		12			3,111	38
39	Air Handler	1995	1,668		7			1,668	39
40	Above Ground Tank	1995	4,825		20			4,825	40
41	Concrete	1995	5,575		20			5,575	41
42	Furnace	1995	9,618		20			9,618	42
43	Roof	1995	1,290		20			1,290	43
44	Kitchen Sink	1995	1,300		20			1,300	44
45	Road Stone	1996	1,120		5			1,120	45
46	Air Conditioner	1996	2,476	30	20	30		2,476	46
47	Tile	1996	360		5			360	47
48	Sinks	1997	6,470		15			6,470	48
49	Flood Lights	1997	2,550	116	20	116		2,550	49
50	Air Conditioner	1997	4,055	185	20	185		4,055	50
51	Sidewalk	1997	6,691	334	20	334		6,691	51
52	Black Top Parking Lot	1997	85,125		15			85,125	52
53	Smoke Detectors	1997	16,100		15			16,100	53
54	Roof	1997	7,070	353	20	353		6,982	54
55	Counters	1997	3,706		15			3,706	55
56	Fire Alarm System	1998	3,660	183	20	183		3,553	56
57	Acoustical Ceiling	1998	1,650	83	20	83		1,603	57
58	Sidewalk Repair	1998	5,660	283	20	283		5,376	58
59	Duct Work	1998	1,017	51	20	51		967	59
60	Tile Repair	1998	650		5			650	60
61	Air Conditioner	1998	2,742		15			2,742	61
62	Carpet	1998	1,544		7			1,544	62
63	Driveway Repairs	1998	2,372		15			2,372	63
64	Roof	1998	2,000	100	20	100		1,874	64
65	Dry Valve	1998	1,540		10			1,540	65
66	Roof	1999	5,970	299	20	299		5,523	66
67	Dry Valve	1999	1,815		10			1,815	67
68	Tile	1999	2,600		5			2,600	68
69	Acoustical Ceiling	2000	6,750	338	20	338		5,764	69
70	TOTAL (lines 4 thru 69)		\$ 414,748	\$ 2,355		\$ 2,355	\$	\$ 412,613	70

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

Facility Name & ID Number Milestone-Elmwood Heights

0024943

Report Period Beginning:

07/01/16

Ending:

06/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 414,748	\$ 2,355		\$ 2,355	\$	\$ 412,613	1
2	Carpet	2000	12,538		5			12,538	2
3	Counter Tops	2000	1,622		15			1,622	3
4	Automatic Doors	2002	4,148		5			4,148	4
5	Tile	2002	2,760		5			2,760	5
6	Water Heater	2002	4,200		10			4,200	6
7	Water Heater	2002	8,135		5			8,135	7
8	Carpet	2002	2,232		5			2,232	8
9	Tile	2002	2,160		5			2,160	9
10	Cabinets	2003	2,449	163	15	163		2,300	10
11	Sump Pump	2003	7,218		10			7,218	11
12	Carpet	2003	8,950		5			8,950	12
13	Air Conditioner	2003	4,705		10			4,705	13
14	Carpet	2003	5,310		5			5,310	14
15	Cabinets	2003	2,409	161	15	161		2,236	15
16	Water Heater	2003	3,694		5			3,694	16
17	Acoustical Ceilings	2004	11,040	552	20	552		7,452	17
18	Carpet	2004	2,094		7			2,094	18
19	Remove ceiling tile & install drywall ceilings	2004	20,380	1,359	15	1,359		18,228	19
20	Carpet	2004	5,058		7			5,058	20
21	Thermostatic control system for heat and air	2004	29,322	1,466	20	1,466		19,427	21
22	Heater	2004	4,660		10			4,660	22
23	Cabinets	2004	8,204	547	15	547		7,156	23
24	Carpet	2004	27,534		7			27,534	24
25	Smoke & Heat Detectors	2004	6,945		10			6,945	25
26	Vinyl Floor	2004	7,242		7			7,242	26
27	Vinyl Floor	2005	5,102		7			5,102	27
28	Cabinets	2005	20,031	1,335	15	1,335		16,402	28
29	Counter Tops	2005	3,097	207	15	207		2,564	29
30	Ceramic Tile	2005	3,377		7			3,377	30
31	Water Pipe Repair	2005	8,955	358	25	358		4,298	31
32	Roof	2005	6,425	321	20	321		3,855	32
33	Replace Sidewalk	2005	10,808	540	20	540		6,394	33
34	TOTAL (lines 1 thru 33)		\$ 667,552	\$ 9,364		\$ 9,364	\$	\$ 632,609	34

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

Facility Name & ID Number Milestone-Elmwood Heights

0024943

Report Period Beginning:

07/01/16

Ending:

06/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 667,552	\$ 9,364		\$ 9,364	\$	\$ 632,609	1
2	Furnaces(8)	2006	20,135	1,007	20	1,007		11,420	2
3	Office Remodel	2006	3,870	258	15	258		2,924	3
4	Neo Flooring	2006	9,476		7			9,476	4
5	Cabinets	2006	20,176	1,345	15	1,345		15,132	5
6	Furnace & Air Conditioner	2006	3,295	165	20	165		1,840	6
7	Acoustical Ceiling	2006	6,000	300	20	300		3,350	7
8	Activity Room Remodel	2006	8,980	599	15	599		6,685	8
9	Vinyl Flooring	2006	4,418		7			4,418	9
10	Carpet	2006	22,509		7			22,509	10
11	Furnaces(4)	2006	12,861	643	20	643		6,860	11
12	Concrete Curb&Gutter	2006	14,906	745	20	745		7,913	12
13	Furnace	2007	9,162	458	20	458		4,657	13
14	Water Heater	2007	3,396		5			3,396	14
15	Carpet	2007	18,229		7			18,229	15
16	Vinyl Flooring	2007	6,135		7			6,135	16
17	Gas Water Heater	2007	5,184		5			5,184	17
18	Fire Suppression System	2007	3,325	333	10	333		3,242	18
19	Furnaces(4)	2007	9,514	476	20	476		4,598	19
20	Doors	2007	16,161	1,077	15	1,077		10,325	20
21	Carpet	2008	5,429		7			5,429	21
22	Blacktop Parking Lot	2007	78,292	5,220	15	5,220		48,716	22
23	Fans & Supplies	2008	6,849	342	20	342		2,997	23
24	Service Fire Alarm System	2008	6,848	685	10	685		5,992	24
25	Concrete Ramp	2008	4,136	207	20	207		1,809	25
26	Service Fire Alarm System	2009	3,370	337	10	337		2,780	26
27	Carpet	2009	17,562		5			17,562	27
28	Covered Walkway	2009	850,010	34,000	25	34,000		274,804	28
29	Blacktop Parking Lot	2009	11,142	743	15	743		6,004	29
30	Sidewalks	2009	6,704	335	20	335		2,709	30
31	Double Steel Doors	2009	3,320	221	15	221		1,660	31
32	Carpet	2010	4,878	585	5	585		4,390	32
33	Carpet	2010	13,756					13,756	33
34	TOTAL (lines 1 thru 33)		\$ 1,877,580	\$ 59,445		\$ 59,445	\$	\$ 1,169,510	34

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

Facility Name & ID Number Milestone-Elmwood Heights

0024943

Report Period Beginning:

07/01/16

Ending:

06/30/17

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,877,580	\$ 59,445		\$ 59,445	\$	\$ 1,169,510	1
2	Vinyl Flooring	2010	7,462		5			7,462	2
3	Carpet	2010	12,481		5			12,481	3
4	Walkway Lighting	2010	46,518	3,101	15	3,101		22,225	4
5	Shingles	2010	4,435	296	15	296		2,070	5
6	Blacktop	2010	8,348	557	15	557		3,757	6
7	Air Conditioner	2011	3,696	185	20	185		1,124	7
8	Pipe Repair	2011	15,085	754	20	754		4,588	8
9	Sidewalk	2011	8,656	433	20	433		2,597	9
10	Parking lot	2011	182,656	12,177	15	12,177		69,032	10
11	Fire Protection	2011	4,156	415	10	415		2,320	11
12	Water Drainage Lines	2011	3,500	233	15	233		1,283	12
13	Doors&Frames/2 for laundry rooms, 1 for mechanical room (also	2011	5,107	340	15	340		1,872	13
14	Water Heaters (4)	2012	15,526	2,415	5	2,415		15,526	14
15	Pharmacy Remodel/electrical,counter shutter,windows,cabinetry,a	2012	32,834	2,189	15	2,189		11,309	15
16	PVC Conduit for Pole Lighting	2011	4,350	435	10	435		2,175	16
17	Carpet/living area & bedrooms for 63,64,65,66,67,68 as needed	2012	3,980	796	5	796		3,980	17
18	Automatic Door /Training room door	2012	8,933	893	10	893		4,020	18
19	Repair to Heating and Cooling Unit/removed & repiped hot water	2013	3,843	769	5	769		3,395	19
20	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2013	9,380	1,876	5	1,876		8,016	20
21	3 Automatic Doors-Activity Room, Kitchen 65&66	2013	7,637	764	10	764		3,309	21
22	6 automatic Doors/main enterance,back enterance,kitchen entry fo	2013	17,764	1,776	10	1,776		6,957	22
23	Seal black top and restriped parking lot	2013	7,572	757	10	757		2,966	23
24	sidewalk for 63 @ front door area and rear, sidewalk for maintena	2013	3,059	153	20	153		574	24
25	TheraPure Pipeless Height Adjustable Supine Tub	2013	11,844	1,184	10	1,184		4,442	25
26	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2013	5,319	1,064	5	1,064		3,812	26
27	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2014	3,861	772	5	772		2,445	27
28	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2014	6,105	1,221	5	1,221		3,358	28
29	Install Frame and Door in the nursing department bewtween the 2	2014	4,296	430	10	430		1,110	29
30	Vinyl Flooring&adhesive/kitchens,bathrooms & some bedrooms fo	2014	3,715	743	5	743		1,672	30
31	Furnish and install two boilers and piping for the Core Building	2015	65,188	3,259	20	3,259		5,976	31
32	Carpet/living area & bedrooms for 63,64,65,66,67,68 as needed	2015	5,380	1,076	5	1,076		1,973	32
33	Blacktop seal and repair	2016	5,316	532	10	532		532	33
34	TOTAL (lines 1 thru 33)		\$ 2,405,582	\$ 101,040		\$ 101,040	\$	\$ 1,387,868	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,405,582	\$ 101,040		\$ 101,040	\$	\$ 1,387,868	1
2	HVAC unit	2016	8,140	373		373		373	2
3	Vinyl Flooring&adhisive/kitchens,bathrooms & some bedrooms fo	2016	4,905	899		899		899	3
4	Electrical work, (install ground boxes, 200'2"PVC conduit, pull ne	2016	3,853	642		642		642	4
5	Air compressor, tank, air dryer	2017	4,642	387		387		387	5
6	Roof replacement	2017	41,131	343		343		343	6
7	duct work, venting (replace some venting on the furnace and water	2017	4,475	74		74		75	7
8	Water Heater	2017	3,804	127		127		127	8
9	Allocated Maintenance Building			2,354		2,354			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	TOTAL (lines 1 thru 33)		\$ 2,476,532	\$ 106,239		\$ 106,239	\$	\$ 1,390,714	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 244,487	\$ 31,035	\$ 31,035	\$	5-10 yrs	\$ 183,821	71
72	Current Year Purchases	37,473	1,855	1,855		5-10 yrs	1,854	72
73	Fully Depreciated Assets	661,315				5-10 yrs	661,315	73
74	allocated computer		3,292	3,292				74
75	TOTALS	\$ 943,275	\$ 36,182	\$ 36,182	\$		\$ 846,990	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	see page 27			\$ 663,265	\$ 28,358	\$ 26,558	\$ (1,800)	3	\$ 635,968	76
77										77
78										78
79										79
80	TOTALS			\$ 663,265	\$ 28,358	\$ 26,558	\$ (1,800)		\$ 635,968	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,185,287	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 170,779	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 168,979	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,800)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,873,672	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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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? _____

16. Rental Amount for movable equipment: \$ 6,241 Description: Copier/Fax/Printer YES NO

(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.

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? <input checked="" type="checkbox"/> YES <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	18,312	29,743		48,055
4	Clinical Wages (b)	46,115	59,486		105,601
5	In-House Trainer Wages (c)	9,750	15,168		24,918
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$ 74,177	\$ 104,397	\$	\$ 178,574
10	SUM OF line 9, col. 1 and 2 (e)	\$ 178,574			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	81
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	90
2. From other facilities (f)	
TOTAL TRAINED	171

- (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	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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 3,150	\$ 2,475,905	1
2	Cash-Patient Deposits	79,626	390,481	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	707,124	1,391,990	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		8,572	6
7	Other Prepaid Expenses	(1,013)	10,283	7
8	Accounts Receivable (owners or related parties)		151,217	8
9	Other(specify): <u>A/R other</u>		214,140	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 788,887	\$ 4,642,588	10
B. Long-Term Assets				
11	Long-Term Notes Receivable		317,347	11
12	Long-Term Investments			12
13	Land	102,215	1,727,962	13
14	Buildings, at Historical Cost	5,314,742	24,155,242	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,606,540	5,901,707	16
17	Accumulated Depreciation (book methods)	(5,711,884)	(21,104,561)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	81,448	119,073	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(81,448)	(119,073)	20
21	Restricted Funds		1,238,700	21
22	Other Long-Term Assets (specify):		371,153	22
23	Other(specify): <u>CIP & CSV Insurance</u>		503,911	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,311,613	\$ 13,111,461	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,100,500	\$ 17,754,049	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$ 848,488	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	79,626	390,481	28
29	Short-Term Notes Payable		355,850	29
30	Accrued Salaries Payable		661,928	30
31	Accrued Taxes Payable (excluding real estate taxes)		236,676	31
32	Accrued Real Estate Taxes(Sch.IX-B)		70	32
33	Accrued Interest Payable		54,088	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Pension, Hlth Plan,etc.</u>		761,428	36
37	<u>Intercompany A/P</u>	5,598,502		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,678,128	\$ 3,309,009	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable		134,183	39
40	Mortgage Payable		1,837,818	40
41	Bonds Payable		905,000	41
42	Deferred Compensation		509,156	42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 3,386,157	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,678,128	\$ 6,695,166	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,577,628)	\$ 11,058,883	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,100,500	\$ 17,754,049	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,781,168)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,781,168)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,203,540	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)	\$ 1,203,540	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)	\$ (3,577,628)	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	\$ 7,680,827	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,680,827	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	185,272	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	10,007	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	937	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 196,216	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Gain on Sale of Veh and Recycled Metal</u>	2,034	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,034	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,879,077	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,265,229	31
32	Health Care	3,447,252	32
33	General Administration	1,451,611	33
B. Capital Expense			
34	Ownership	177,973	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	333,472	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,675,537	40
41	Income before Income Taxes (line 30 minus line 40)**	1,203,540	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,203,540	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,058,149	44
45	Private Pay - Net Inpatient Revenue	622,678	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)	\$ 7,680,827	49

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

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

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

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

Facility Name & ID Number Milestone-Elmwood Heights

0024943

Report Period Beginning:

07/01/16

Ending:

06/30/17

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	1,904	2,155	\$ 69,228	\$ 32.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,630	8,166	191,569	23.46	3
4	Licensed Practical Nurses	16,969	18,767	416,058	22.17	4
5	CNAs & Orderlies					5
6	CNA Trainees	18,758	18,758	178,574	9.52	6
7	Licensed Therapist	450	450	29,266	65.04	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	685	832	22,704	27.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,928	10,162	113,404	11.16	15
16	Dishwashers					16
17	Maintenance Workers	6,958	7,827	121,695	15.55	17
18	Housekeepers	10,048	11,280	114,269	10.13	18
19	Laundry					19
20	Administrator	1,398	1,631	67,526	41.40	20
21	Assistant Administrator					21
22	Other Administrative	461	475	34,443	72.51	22
23	Office Manager	4,808	5,572	130,375	23.40	23
24	Clerical	1,792	2,171	24,780	11.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	34,836	37,908	605,392	15.97	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	123,405	134,825	1,448,021	10.74	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	239,030	260,979	\$ 3,567,304 *	\$ 13.67	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	14	\$ 480	1-3	35
36	Medical Director	120	27,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,494	49,146	10-3	38
39	Pharmacist Consultant	74	4,440	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental</u>	245	12,264	10-3	46
47	<u>Behavioral Therapist</u>	27	1,080	10-3	47
48	<u>Psychologist/Psychiatrist</u>	555	60,518	10-3	48
49	TOTAL (lines 35 - 48)	2,529	\$ 154,928		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Linda Thornbloom</u>			\$ <u>67,526</u>	<u>Workers' Compensation Insurance</u>	\$ <u>101,468</u>	<u>IDPH License Fee</u>	\$	
<u>Corp. Admin Salaries</u>			<u>34,443</u>	<u>Unemployment Compensation Insurance</u>		<u>Advertising: Employee Recruitment</u>	<u>8,587</u>	
				<u>FICA Taxes</u>	<u>261,952</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>599,539</u>	(Indicate # of checks performed _____)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Dues</u>	<u>264</u>	
				<u>Employee Physical Exams</u>	<u>4,490</u>	<u>Fees</u>	<u>3,947</u>	
				<u>Other Employee Benefits</u>	<u>10,772</u>	<u>Subscriptions,Books & Periodicals</u>	<u>289</u>	
				<u>Applicant Referral</u>	<u>3,431</u>			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ <u>101,969</u>	<u>Pension</u>	<u>31,760</u>			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ <u>1,013,412</u>	Less: Public Relations Expense	(_____)	
			\$ _____			Non-allowable advertising	(_____)	
			_____			Yellow page advertising	(_____)	

TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ _____					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>RSM McGladrey</u>	<u>Pension Plan</u>		\$ <u>504</u>			\$ _____	<u>Out-of-State Travel</u>	\$ _____
<u>Various</u>	<u>Computer/Programmer Cslt.</u>		<u>384</u>					
<u>Wipfli LLP</u>	<u>Audit</u>		<u>7,528</u>					
<u>Williams&McCarthy</u>	<u>Legal Fees</u>		<u>6,694</u>				<u>In-State Travel</u>	
<u>Peggy Brechon</u>	<u>Administrative Consultant</u>		<u>1,500</u>					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ <u>16,610</u>				<u>Seminar Expense</u>	<u>3,682</u>
							<u>Entertainment Expense</u>	(_____)
				TOTAL		\$ _____	(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ <u>3,682</u>

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Milestone-Elmwood Heights

0024943

Report Period Beginning: 07/01/16

Ending: 06/30/17

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? 5 & 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 333,472
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. \$ _____ Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
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? _____
Firm Name: WIPFLI LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. yes
Attach invoices and a summary of services for all architect and appraisal fees

SCHEDULE VII-A: BOARD MEMBER LISTING

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

SCHEDULE VII-A: RELATED PARTIES

<u>MILESTONE, INC.</u>	RESIDENTIAL <u>BEDS</u>	<u>CITY</u>	TYPE OF <u>BUSINESS</u>
Central Office	N/A	Rockford	Central Office
Elmwood Heights	84	Rockford	ICF/MR-SLC
Elmwood East	12	Rockford	ICF/DD<16 & Fewer
Searles	12	Rockford	ICF/DD<16 & Fewer
Sun Valley	8	Rockford	ICF/DD<16 & Fewer
Applewood	8	Loves Park	C.I.L.A. Services
Orchard	8	Rockford	C.I.L.A. Services
Training Center	N/A	Rockford	Developmental Training
Industries	N/A	Loves Park	Developmental Training
RocVale Childrens Home	50	Rockford	Children's Group Home DD
Shattuck	5	Rockford	C.I.L.A. Services
Eggleston	5	Rockford	C.I.L.A. Services
Dierks	8	Rockford	C.I.L.A. Services
Geneva	5	Rockford	C.I.L.A. Services
C.I.L.A.	22	Rockford	C.I.L.A. Services
Windcloud	5	Rockford	C.I.L.A. Services
Prospect	5	Rockford	C.I.L.A. Services
Hanford	5	Rockford	C.I.L.A. Services
Rural	5	Rockford	C.I.L.A. Services
Flintridge	5	Rockford	C.I.L.A. Services
Old Golf	8	Loves Park	C.I.L.A. Services
Creekside	5	Rockford	C.I.L.A. Services
Hermitage	5	Rockford	C.I.L.A. Services
Javelin II	5	Rockford	C.I.L.A. Services
Windpoint	5	Rockford	C.I.L.A. Services
Weymouth	5	Rockford	C.I.L.A. Services
Fleetwood	5	Rockford	C.I.L.A. Services
Stornway	5	Rockford	C.I.L.A. Services
Shiloh	6	Rockford	C.I.L.A. Services
Black Oak	5	Rockford	C.I.L.A. Services
Donna Drive	8	Rockford	C.I.L.A. Services
Respite Services	N/A	Rockford	Respite Services
Sawgrass	6	Rockford	C.I.L.A. Services
Crested Butte	6	Rockford	C.I.L.A. Services
Dental Program	N/A	Rockford	Dental Services
Thyme	7	Rockford	C.I.L.A. Services
Tulip	5	Rockford	C.I.L.A. Services
Packard	5	Rockford	C.I.L.A. Services
Apawamis	4	Rockford	C.I.L.A. Services
Southbridge	5	Rockford	C.I.L.A. Services
South Mulford	8	Rockford	C.I.L.A. Services
Commonwealth	8	Rockford	C.I.L.A. Services
HUD Project #071-EH003	N/A	Rockford	Housing
HUD Project #071-EH059	N/A	Rockford	Housing
HUD Project #071-EH178	N/A	Rockford	Housing
HUD Project #071-HD160	N/A	Rockford	Housing
HUD Project #071-HD169	N/A	Rockford	Housing
Bingo	N/A	Rockford	Bingo

RECLASSIFICATION - SCHEDULE V. COLUMN 5

SCHEDULE
V

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

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

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

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

Schedule of Federal Form 990 Reconciliation

Page 19, Line 41	\$1,203,540
	(\$636,493) Related Organizational Net Income
Federal Form 990 Net Income	<u>\$567,047</u>

Asset Listing - VEHICLES

<u>Description</u>	<u>Date Acquired</u>	<u>Cost</u>		<u>Current Book Depreciation</u>	<u>Life in Years</u>	<u>Straight Line Depreciation</u>	<u>Adjustments</u>	<u>Accumulated Depreciation</u>
04 Ford Crown Victoria	09/30/03	21,529.92	(A)	0.00	S/L-3 YE	0.00	(1,800.00)	21,529.92
Van Lift	06/17/04	3,735.00		0.00	S/L - 5	0.00		3,735.00
Van Lift	06/17/04	3,735.00		0.00	S/L-5YRS	0.00		3,735.00
04 Ford Freestar	08/25/04	18,347.26		0.00	S/L- 3 Y	0.00		18,347.26
05 Ford Van E150	02/18/05	18,539.58		0.00	S/L-3 YR	0.00		18,539.58
2006 Club Wagon	08/16/05	22,035.60		0.00	S/L-3 YR	0.00		22,035.60
05 Ford Eldorado	10/20/05	47,091.00		0.00	S/L-3 YR	0.00		47,091.00
97 Bus Repairs	11/30/05	10,152.19		0.00	S/L-3 YR	0.00		10,152.19
Bus Repairs	01/10/06	10,458.84		0.00	S/L-3 YR	0.00		10,458.84
06 Ford E350	10/11/06	22,040.40		0.00	S/L-3 YR	0.00		22,040.40
07 Ford Crown Vic	10/26/06	20,611.50		0.00	S/L-3 YR	0.00		20,611.50
06 Ford Eldorado	01/12/07	43,791.00		0.00	S/L-3 YR	0.00		43,791.00
08 Ford Econoline	05/30/08	23,420.00		0.00	S/L-3 YR	0.00		23,420.00
09 Ford Econoline	09/15/08	24,285.00		0.00	S/L-3 YR	0.00		24,285.00
09 Ford Econoline	09/26/08	25,679.00		0.00	S/L-3 YR	0.00		25,679.00
09 Ford Escape	10/06/08	22,741.00		0.00	S/L-3 YE	0.00		22,741.00
10 Ford Lift Van	01/21/10	54,594.00		0.00	S/L-3 YR	0.00		54,594.00
10 Ford Lift Van	01/21/10	54,594.00		0.00	S/L-3 YR	0.00		54,594.00
11 Dodge Caravan	07/08/11	23,419.00		0.00	S/L-3 YR	0.00		23,419.00
12 Ford Taurus	09/16/11	26,852.00		0.00	S/L-3 YR	0.00		26,852.00
12 Ford Truck F-250	08/24/12	23,733.39		0.00	S/L-3 YR	0.00		23,733.39
Plow for Ford Truck	08/23/12	4,338.00		0.00	S/L-3 YR	0.00		4,338.00
04 Ford Truck F250	10/05/12	6,419.00		0.00	S/L-3 YR	0.00		6,419.00
13 Ford E350	07/17/13	52,810.00		0.16	S/L-3 YR	0.16		52,810.00
14 Ford Taurus	05/13/14	12,456.27		3,460.01	S/L-3 YR	3,460.01		12,456.27
Plow	09/15/14	8,400.00		2,799.96	S/L-3 YR	2,799.96		7,933.22
15 Ford F250	11/03/14	26,003.00		8,667.72	S/L-3 YR	8,667.72		23,113.92
15 Ford Transit Connect	12/31/14	31,225.00		10,408.32	S/L-3 YR	10,408.32		26,020.80
17 Ford Taurus	02/28/17	21,759.00		3,022.10	S/L-3 YR	3,022.10		3,022.10
Less: A) Disposals		(21,529.92)						(21,529.92)
B) Gain on Sale of Fixed Assets						(1,800.00)		
C) Insurance Reimbursement						0.00		
TOTALS		<u>663,265.03</u>		<u>28,358.27</u>		<u>26,558.27</u>	<u>(1,800.00)</u>	<u>635,968.07</u>

Legal Fees

Williams & McCarthy

<u>Invoice Date</u>	<u>Check #</u>	<u>Amount</u>	<u>Description of Services</u>
09/22/16	196164	270.00	General Employment Matters
03/24/17	198126	2,025.00	General Employment Matters
04/24/17	198274	750.00	General Employment Matters

Milestone, Inc. - ELMWOOD HEIGHTS # 0024943
Schedule of In-Service Training
FY 2017

<u>CHECK DATE</u>	<u>AMOUNT</u>	<u>VENDOR</u>	<u>DESCRIPTION</u>
08/26/16	4,601.25	National Alliance for Direct Support Professional	Seminar/Building a Culture of Competence
09/27/16	287.95	Laerdal	CPR & First Aid Training Materials
02/22/17	344.25	Laerdal	CPR & First Aid Training Materials
11/14/16	90.35	AED Essentials	CPR & First Aid Training Materials
03/31/17			
TOTAL	<u>\$ 5,323.80</u>		