Submitted Application for: DHS 75.54 Application

Provider

Provider Name: Legacy Recovery Center
Provider Number:

Physical Address: W332S9291 Red Brae drive Mukwonago, 53149
Mailing Address: W332S9291 Red Brae drive, , 53149
County:
Phone:

Primary Contact

Name: RichardMiller
Email [redacted]
Phone:

Attestation

The signatory of this document is duly authorized by the applicant / owner to sign this agreement on their behalf. The applicant / owner hereby accepts responsibility for knowing and ensuring compliance with all licensing and operational requirements for this facility.

I attest, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge. ☐

Application Type: New Facility

Licensee Type:

Application Questions

Is the person completing this application the same as the facility/program primary contact?

Is the building/address associated with this application, currently licensed as a DHS 83 Community Based Residential Facility (CBRF) or currently a residential service that is licensed as a DHS 124 Hospital?

Are any other facilities associated with this owner or corporate entity?

Plan Review

I/We confirm that the Plan Review information has been submitted with appropriate fees. ☐

Physical Environment Review Question

Please enter the estimated cost of work submitted for the required plan review project.

Resident Details

Capacity: 8
Gender: Both
Status: Ambulatory
Age Group: <Values><Value ValuePK ="104506">Adults (ages 18 and over)</Value></Values>

Employee

The signatory of this document is duly authorized by the applicant / owner to sign this agreement on their behalf. The applicant / owner hereby accepts responsibility for knowing and ensuring compliance with all licensing and operational requirements for this facility.

I attest, I have entered in the Complete Roster of employees for the provider to the best of my knowledge. ☐

Primary Contact Information

I/We confirm that the Primary Contact has been added to the Provider. ☐

Background Checks

I/We confirm that the background information for every currently known individual of this Provider has been submitted. ☒

Fit and Qualified

I Attest, that I have submitted all needed fit and qualified reviews. ☐

DHS 75.54 Application Fee(s)

Application Fee:	**$1100.00**
Physical Environmental Fee:	**$1100.00**

Department of Health Services **State of Wisconsin**
Division of Quality Assurance
F-00593 (03/2026)

Provider Agreement for Electronic Statements of Deficiency and Plans of Correction

Instructions

- Read this form carefully before signing.
- This form must be signed by an authorized representative of the entity entering into this agreement.
- This agreement shall remain in effect until revoked by the provider or when any of the provider information below changes, at which time a new agreement must be executed.

Note: Completion of this agreement is necessary for provider participation in the electronic SOD and POC process.

Provider information

Name – Provider: Legacy Recovery Center,LLC

License/Certification number: app#3938 / app#0022171

Address – Street: W332S9291 Red Brae Drive

City: Mukwonago State: WI ZIP code: 53149

Authorized representative information

Name – CEO/Administrator: Richard Miller-CEO

Email: richard@legacyrecoverycenter.com Phone number: 936-615-0981

Name – Additional recipient: Danielle Miller-Administrator

Email: [redacted] Phone number: [redacted]

By signature of the provider's authorized representative below, the provider agrees to:

1. Accept electronic (email) service of Statements of Deficiency (SODs). It is recommended that the provider checks incoming email daily to ensure timely receipt of SODs and to acknowledge receipt with a reply email to the sender.
2. Not alter the original eSOD or other documents not intended to be completed by the provider.
3. Complete Plans of Correction (POCs) using the supplied DQA form F-00344, Plan of Correction.
4. Return completed form(s) F-00344, Plan of Correction, to the Division of Quality Assurance via email.
5. Notify DQA promptly of any change in the provider's Authorized Representative or Additional Recipient to whom emails are to be sent.
6. Accept and adhere to the following terms:
    a. The effective date of service for Statements of Deficiency is the date the transmitting email message is sent from the Division of Quality Assurance to the Authorized Representative named above.
    b. Failure by the Authorized Representative or his/her designated agent to open the transmitting email does not delay or alter the effective date of service for Statements of Deficiency.
    c. Failure by the Authorized Representative or his/her designated agent to reply to the transmitting email with an acknowledgement of receipt does not constitute refusal to accept service of the Statement of Deficiency or change any other terms of this agreement.
    d. The facility acknowledges that it has the ability to open and read PDF documents. If the facility is unable to open or view a file sent by DHS, it is incumbent upon the facility to notify the appropriate DHS regional office to request a new file.

Signature — Authorized representative: Richard Miller Date signed: 8/25/26

TG Analytical Laboratories
N1022 Quality Drive
Greenville, WI 54942

Walworth County Department of Health and Human Services
1910 CR NN
Elkhorn, WI 53121

Water Analysis Report

Reason/Sample ID:		Date of Sample Collection:	**Feb 05, 2026**
Owner/Facility:	**LEGACY RECOVERY CENTER**	Time of Sample Collection:	**9:45 AM**
Address:	**W332 S9291 RED BRAE DR**	Date Received:	**Feb 11, 2026**
City, State, Zip:	**MUKWONAGO, WI 53149**	Report Date:	**Feb 12, 2026**
Reason for Test:	**Other**	Collected By:	**SCOTT MARTIN**
Lab Sample ID:	**20277316**	Sample Location:	**Pressure Tank Tap**

Test	Result	Interpretation	LOD/LOQ (ug/L)	Method	Test Date	Analyst
Arsenic	**ND**	**"SAFE"**	**1/3.33**	**SM3113B**	**Feb 12, 2026**	**MN**

MCL: 10 ug/L **Data Qualifier: A** **Dilution Factor: 1**

Consumption of water with arsenic levels exceding the MCL may cause skin damage, problems with the circulatory system, and an increased risk of cancer. Some of the main sources of arsenic include erosion of natural deposits, runoff from orchards, and runoff from glass & electronic production waste water.

List of Abbreviations:
LOD = Limit of Detection
LOQ = Limit of Quantification
MCL = Maximum Contaminant Level
ND = Non-Detectable, Result less than the LOD
[..] = Result between LOD and LOQ
1 mg/L = 1 part per million (ppm)
1 ug/L = 1 part per billion (ppb)

List of Data Qualifiers:
A=All QC Passed, B=method blank>LOD, C=chlorine present, D=sample between LOD and LOQ, E=not enough sample, F=gross deficiencies in QC, G=spike or spike duplicate out of spec., H=a check standard out of spec., I=blank>LOD, J=ICV out of spec, K=sample exceeds holding time limit, L=temperature not in range, M-sample container didn't meet requirements, N=blank>LOD, O=holding time > 30 hours but <48 hours, P=sample <100mL for coliform analysis, Q=SD>20%, R=misc. NC=Non-Certified
Documentation of this analysis will be maintained for at least seven years.

The information above was obtained from the Environmental Protection Agency's internet web page: epa.gov.
'SAFE' and 'UNSAFE' interpretations are based on EPA 40 CFR 141.23 and 40 CFR 141.63.
For sample results requiring adjustment for dilutions, the detection and quantitation limits have not been adjusted for the corresponding sample dilutions.

Notes:

Sample Received By: MN
Arsenic: Digestion Required;

Approved By:

Dan Schlenz, MWS
Lab Director
Lab #105-452

WDNR Certification: #445158340
WDATCP Certification: 142250-D3