

Facility Name & ID Number Medina Nursing Center

0011551 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 N/A

	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	89	Skilled (SNF)	89	32,485	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,485	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	861		2,299	3,160	8
9	SNF/PED					9
10	ICF	15,757	8,524		24,281	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,618	8,524	2,299	27,441	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.47%

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

0 (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)

None

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

Non-allowable costs have been eliminated in Schedule V, Column 7.

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 1965

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

YES Date N/A NO

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

YES NO If YES, enter number of beds certified 89 and days of care provided 2,299

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	227,684	27,200	5,486	260,370		260,370		260,370		1
2	Food Purchase		185,043		185,043		185,043	(12,431)	172,612		2
3	Housekeeping	78,043	30,529		108,572		108,572		108,572		3
4	Laundry	70,561	7,720		78,281		78,281		78,281		4
5	Heat and Other Utilities			78,893	78,893		78,893		78,893		5
6	Maintenance	57,506	18,871	45,213	121,590		121,590		121,590		6
7	Other (specify):*										7
8	TOTAL General Services	433,794	269,363	129,592	832,749		832,749	(12,431)	820,318		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,028,014	95,966	219,095	1,343,075		1,343,075		1,343,075		10
10a	Therapy		1,231	231,928	233,159		233,159		233,159		10a
11	Activities	53,324	3,739	12,084	69,147		69,147		69,147		11
12	Social Services	64,606		7,887	72,493		72,493		72,493		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,145,944	100,936	476,994	1,723,874		1,723,874		1,723,874		16
	C. General Administration										
17	Administrative	150,212			150,212		150,212		150,212		17
18	Directors Fees										18
19	Professional Services			102,212	102,212		102,212	(12,526)	89,686		19
20	Dues, Fees, Subscriptions & Promotions			16,899	16,899		16,899		16,899		20
21	Clerical & General Office Expenses	83,487	30,156	13,193	126,836		126,836	(264)	126,572		21
22	Employee Benefits & Payroll Taxes			348,403	348,403		348,403		348,403		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,125	14,125		14,125	(1,504)	12,621		24
25	Other Admin. Staff Transportation			7,923	7,923		7,923		7,923		25
26	Insurance-Prop.Liab.Malpractice			13,314	13,314		13,314		13,314		26
27	Other (specify):*										27
28	TOTAL General Administration	233,699	30,156	516,069	779,924		779,924	(14,294)	765,630		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,813,437	400,455	1,122,655	3,336,547		3,336,547	(26,725)	3,309,822		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Medina Nursing Center

#0011551

Report Period Beginning:

01/01/06

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			87,303	87,303		87,303	22,425	109,728			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,760	4,760		4,760	(800)	3,960			32
33	Real Estate Taxes			45,836	45,836		45,836		45,836			33
34	Rent-Facility & Grounds			54,000	54,000		54,000	(54,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			191,899	191,899		191,899	(32,375)	159,524			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			416	416		416		416			38
39	Ancillary Service Centers		64,870	74	64,944		64,944		64,944			39
40	Barber and Beauty Shops	11,325	304	171	11,800		11,800		11,800			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,728	48,728		48,728		48,728			42
43	Other (specify):* Nonallowable Cost			43,702	43,702		43,702	(43,702)				43
44	TOTAL Special Cost Centers	11,325	65,174	93,091	169,590		169,590	(43,702)	125,888			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,824,762	465,629	1,407,645	3,698,036		3,698,036	(102,802)	3,595,234			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning:

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Ending:

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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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,431)	2		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	15,539	30		9
10	Interest and Other Investment Income	(800)	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	(5,151)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,739)	43		28
29	Other-Attach Schedule See Pg 5A	(45,106)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,688)		\$	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)	(47,114)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (47,114)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (102,802)		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.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center

Report Period Beginning: 01/01/06
Ending: 12/31/06

ID# 0011551

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow PAC convention fees	\$ (250)	24	1
2	Disallow non-allowable travel & seminar expense	(1,254)	24	2
3	Disallow out of period legal fees	(12,526)	19	3
4	Offset vending machine revenue	(7,087)	43	4
5	Disallow non-allowable association dues	(5,402)	43	5
6	Disallow non-allowable donations	(5,696)	43	6
7	Disallow IDPH sanction fees	(3,050)	43	7
8	Disallow Medicare Lab expense	(5,286)	43	8
9	Disallow Medicare X-Ray expense	(1,291)	43	9
10	Disallow state income tax expense	(3,000)	43	10
11	Offset office income against related expense	(264)	21	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	(45,106)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Medina Nursing Center# 0011551

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	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	(12,431)	0	0	0	0	0	0	0	0	0	0	(12,431)	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	(12,431)	0	(12,431)	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	(12,526)	0	0	0	0	0	0	0	0	0	0	(12,526)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(264)	0	0	0	0	0	0	0	0	0	0	(264)	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	(1,504)	0	0	0	0	0	0	0	0	0	0	(1,504)	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	(14,294)	0	(14,294)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(26,725)	0	(26,725)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	15,539	6,886	0	0	0	0	0	0	0	0	0	22,425	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(800)	0	0	0	0	0	0	0	0	0	0	(800)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(54,000)	0	0	0	0	0	0	0	0	0	(54,000)	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	14,739	(47,114)	0	(32,375)	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):*	(43,702)	0	0	0	0	0	0	0	0	0	0	(43,702)	43
44	TOTAL Special Cost Centers	(43,702)	0	0	0	0	0	0	0	0	0	0	(43,702)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(55,688)	(47,114)	0	(102,802)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Holgeir J. Oksnevad	100	N/A		Medina Manor Building, Inc.	Durand	Lessor
				Owner Johs Oksnevad is the father of Holgeir Oksnevad		

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	30 Depreciation	\$	Medina Manor Building, Inc.		\$ 6,886	\$ 6,886	1
2	V	34 Rent	54,000	Medina Manor Building, Inc.			(54,000)	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		\$ 54,000			\$ 6,886	\$ * (47,114)	14

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Holgeir Oksnevad	President	Administrator	100.00	None	50+	100.00	Salary	\$ 150,212	L17, C1	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	\$ 150,212		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center

0011551 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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
2									2
3									3
4									4
5									5
6				N/A					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	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Medina Nursing Center

0011551

Report Period Beginning:

01/01/06

Ending:

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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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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	M&I Dealer Finance		X	Vehicle Loan	\$920.60	2/22/2004	\$ 55,236	\$ 22,047	2/22/09	0.0399	\$ 1,096	1						
2	State Bank of Davis		X	Vehicle Loan	\$784.02	10/20/05	40,070	31,235	10/20/10	0.0650	2,284	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Durand State Bank		X	Working Capital	None	12/31/02	Varies	25,100	03/31/07	0.0675	1,380	6						
7												7						
8												8						
9	TOTAL Facility Related				\$1,704.62		\$ 95,306	\$ 78,382			\$ 4,760	9						
B. Non-Facility Related*																		
10												10						
11										Disallow non-allowable interest	(800)	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (800)	14						
15	TOTALS (line 9+line14)						\$ 95,306	\$ 78,382			\$ 3,960	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Medina Nursing Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0011551

CONTACT PERSON REGARDING THIS REPORT Charles J. Fischer

TELEPHONE (312) 634-4580 FAX #: (312) 634-5518

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-15-251-001</u>	<u>Medina Manor Building</u>	\$ <u>892.88</u>	\$ <u>892.88</u>
2. <u>05-15-251-002</u>	<u>Medina Manor Building</u>	\$ <u>41,030.84</u>	\$ <u>41,030.84</u>
3. <u>05-15-251-003</u>	<u>Medina Manor Building</u>	\$ <u>912.44</u>	\$ <u>912.44</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>42,836.16</u>	\$ <u>42,836.16</u>

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 X NO

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Medina Nursing Center

0011551

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,000 B. General Construction Type: Exterior Brick Frame Masonry, Fire Resistan Number of Stories 2

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).

Medina Manor Apartments

Retirement Apartments

22 units

20,000 Sq. ft

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

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>7 acres</u>	<u>1965</u>	<u>\$ 3,048</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 3,048	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	64	1965	1965	\$ 488,644	\$	30	\$	\$	\$ 488,644	4
5	25	1980	1980	158,173		30	5,272	5,272	142,505	5
6										6
7										7
8										8
	Improvement Type**									
9	Building Improvements		1968	675		15			675	9
10	Building Improvements		1974	861		10			861	10
11	Building Improvements		1975	1,547		10			1,547	11
12	Building Improvements		1976	345		9			345	12
13	Building Improvements		1977	12,614		21			12,614	13
14	Building Improvements		1977	2,793		8			2,793	14
15	Building Improvements		1979	2,620		7			2,620	15
16	Building Improvements		1980	24,465		20			24,465	16
17	Building Improvements		1980	2,137		7			2,137	17
18	Building Improvements		1981	20,211		15			20,211	18
19	Building Improvements		1982	2,305		20			2,305	19
20	Building Improvements		1983	705		5			705	20
21	Building Improvements		1985	980		10			980	21
22	Building Improvements		1985	3,091	103	20		(103)	3,091	22
23	Building Improvements		1986	17,543		10			17,543	23
24	Building Improvements		1987	56,373		20	2,819	2,819	54,961	24
25	Building Improvements		1988	14,212		20	711	711	13,146	25
26	Building Improvements		1989	30,063		20	1,503	1,503	26,304	26
27	Building Improvements		1990	1,601		20	80	80	1,324	27
28	Building Improvements		1991	51,619	1,147	20	2,581	1,434	40,005	28
29	Building Improvements		1991	11,626		20	581	581	8,427	29
30	Building Improvements		1992	39,070	2,605	20	1,954	(651)	26,377	30
31	Building Improvements		1992	3,295	203	20	165	(38)	2,390	31
32	Building Improvements		1992	19,372		20	969	969	14,048	32
33	Building Improvements		1992	23,809	2,362	20	1,190	(1,172)	17,255	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	Building Improvements	1993	\$ 37,059	\$ 2,471	20	\$ 1,853	\$ (618)	\$ 25,018	37
38	Building Improvements	1993	100,000		20	5,000	5,000	66,669	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	33,689	39
40	Building Improvements	1994	15,610		10			15,610	40
41	Building Improvements	1995	47,826	3,188	15	3,188		36,663	41
42	Building Improvements	1995	36,144	2,410	15	2,410		27,714	42
43	Outdoor Signs	1996	2,149	143	15	143		1,502	43
44	Backflow Preventors	1996	3,679	245	15	245		2,573	44
45	Garbage Disposal	1996	761	51	15	51		535	45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		1,605	46
47	Door	1997	1,996	133	15	133		1,264	47
48	Sign	1997	666	44	15	44		419	48
49	Air Conditioner	1997	3,500	233	15	233		2,214	49
50	Lights	1997	621	41	15	41		390	50
51	Driveway	1997	2,875	192	15	192		1,824	51
52	Fire Alarm	1997	1,246	83	15	83		789	52
53	Plumbing	1997	5,122	341	15	341		3,240	53
54	Telephone System	1997	1,152	77	15	77		707	54
55	Permanent Outdoor Receptacles	1997	585	39	15	39		371	55
56	Office Remodeling	1998	2,454	164	15	164		1,394	56
57	Exterior Doors	1998	7,652	510	15	510		4,335	57
58	Windows	1998	15,536	1,036	15	1,036		8,806	58
59	Roof Repair	1998	2,317	154	15	154		1,309	59
60	Water and Sewer Improvements	1998	3,165	211	15	211		1,792	60
61	Fire Alarm	1998	1,157	77	15	77		655	61
62	Telephone System	1998	1,467	98	15	98		831	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,341,920	\$ 21,746		\$ 37,012	\$ 15,266	\$ 1,170,196	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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		\$ 1,341,920	\$ 21,746		\$ 37,012	\$ 15,266	\$ 1,170,196	1
2	Blinds	1999	3,689	246	15	246		1,843	2
3	Window Replacement	1999	5,145	305	15	343	38	2,573	3
4	Rewire & Replumb Laundry Room	1999	7,824	481	15	522	41	3,909	4
5	Floor Tile	1999	1,049	70	15	70		525	5
6	Air Conditioning	1999	1,895	126	15	126		945	6
7	Boiler	1999	535	36	15	36		264	7
8	Sidewalk	2000	1,386	92	15	92		598	8
9	Kickplates	2000	608	41	15	41		261	9
10	Landscaping Brick	2000	1,139	76	15	76		494	10
11	Blacktop Parking Lot	2001	15,000	1,000	15	1,000		5,500	11
12	Dumpster Gate Frames	2001	1,650	110	15	110		605	12
13	Dumpster Concrete Platform	2001	3,700	247	15	247		1,358	13
14	Stone Wall	2001	1,665	111	15	111		610	14
15	Video Surveillance	2002	14,865	991	15	991		4,460	15
16	Wrought Iron Fence	2002	5,105	340	15	340		1,530	16
17	Nurses Call System	2002	12,726	848	15	848		3,816	17
18	Custom Doors	2002	9,427	628	15	628		2,826	18
19	Windows Framing	2003	11,656	777	15	777		2,720	19
20	Roof	2003	7,470	498	15	498		1,743	20
21	Alarm Installation	2003	12,730	849	15	849		2,971	21
22	Cabinets	2004	504	34	15	34		85	22
23	Surveillance Cameras	2004	578	39	15	39		96	23
24	Time Clock	2004	10,000	667	15	667		1,666	24
25	Latches	2004	8,923	595	15	595		1,486	25
26	Exhaust Hood	2004	4,290	286	15	286		715	26
27	Bath Call Light	2004	1,229	82	15	82		205	27
28	Ventilator	2004	1,038	69	15	69		174	28
29	Driveway	2004	4,000	267	15	267		666	29
30	Sidewalk & Driveway	2005	5,209	347	15	347		520	30
31	Wiring & Outlets	2005	8,903	594	15	594		890	31
32	Windows	2005	1,911	127	15	127		191	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,507,769	\$ 32,725		\$ 48,070	\$ 15,345	\$ 1,216,441	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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 12B, Carried Forward		\$ 1,507,769	\$ 32,725		\$ 48,070	\$ 15,345	\$ 1,216,441	1
2	Flag Poles	2005	4,362	291	15	291		436	2
3									3
4	Fire Alarm System	2006	12,455	415	15	415		415	4
5	Doors and Gaskets	2006	6,545	218	15	218		218	5
6	Water Softner	2006	965	32	15	32		32	6
7	Landscaping Improvements	2006	2,377	79	15	79		79	7
8	Timeclock	2006	20,715	691	15	691		691	8
9	Roofing	2006	1,350	45	15	45		45	9
10	Fire Door	2006	965	32	15	32		32	10
11	Hot Water Storage Tank	2006	11,998	400	15	400		400	11
12	A/C Compressor	2006	1,777	59	15	59		59	12
13	Fire Alarm Panel	2006	3,200	107	15	107		107	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)		\$ 1,574,478	\$ 35,094		\$ 50,439	\$ 15,345	\$ 1,218,955	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 284,173	\$ 24,977	\$ 27,428	\$ 2,451	5-10	\$ 175,227	71
72	Current Year Purchases	23,154	1,158	1,158		10	1,158	72
73	Fully Depreciated Assets	63,829					63,829	73
74								74
75	TOTALS	\$ 371,156	\$ 26,135	\$ 28,586	\$ 2,451		\$ 240,214	75

D. Vehicle Depreciation (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	Activity Bus	1975 Ford Bus	1985	\$ 9,409	\$	\$	\$	3	\$ 9,409	76
77	Resident Van	1991 Chevy Lumina	1991	18,008				3	18,008	77
78	Activity Bus	1998 Ford Bus	1998	49,705				5	49,705	78
79	From Schedule 13A			153,518	26,074	30,703	4,629	5	67,960	79
80	TOTALS			\$ 230,640	\$ 26,074	\$ 30,703	\$ 4,629		\$ 145,082	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)	\$ 2,179,322	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,303	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 109,728	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,425	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,604,251	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center, Inc.

Provider #: 0011551

1/1/2006 to 12/31/2006

Schedule 13A

XI. Ownership Costs

Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Administrative	2002 Jeep Liberty	2002	30,000	4,286	6,000	(1,714)	5	21,858
Maintenance	2004 F250 Ford Picku	2004	51,020	7,289	10,204	(2,915)	5	24,353
Maintenance	2005 Ford Freestar	2005	8,436	1,687	1,687	-	5	2,531
Administrative	2006 Mercedes	2005	64,062	12,812	12,812	-	5	19,218
TOTAL			\$153,518	\$26,074	\$30,703	(\$4,629)		\$67,960

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A.

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: \$ 0 Description: N/A

(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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

* 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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. 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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	10A(3)	hrs	\$	1,480	\$ 88,824	\$	1,480	\$ 88,824	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist	10A(3)	hrs		792	47,519		792	47,519	3
4	Licensed Physical Therapist	10A(2,3)	hrs		1,593	95,585	1,231	1,593	96,816	4
5	Physician Care		visits							5
6	Dental Care	39(3)	visits		1	74		1	74	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				64,870		64,870	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	3,866	\$ 232,002	\$ 66,101	3,866	\$ 298,103	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0011551
 As of 12/31/06

Report Period Beginning: 01/01/06
 (last day of reporting year)

Ending: 12/31/06

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	\$ (57,824)	\$ (57,573)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 55,000)	709,403	709,403	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,372	13,372	6
7	Other Prepaid Expenses	41,198	41,198	7
8	Accounts Receivable (owners or related parties)	19,000	19,000	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 725,149	\$ 725,400	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,048	13
14	Buildings, at Historical Cost		646,817	14
15	Leasehold Improvements, at Historical Cost	717,546	927,661	15
16	Equipment, at Historical Cost	726,290	601,796	16
17	Accumulated Depreciation (book methods)	(965,895)	(1,604,251)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 477,941	\$ 575,071	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,203,090	\$ 1,300,471	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 18,017	\$ 18,017	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,068	18,068	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,568	32,568	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,854	30,854	31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,000	45,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	6,729	6,729	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 151,236	\$ 151,236	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	78,382	78,382	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 78,382	\$ 78,382	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 229,618	\$ 229,618	46
47	TOTAL EQUITY (page 18, line 24)	\$ 973,472	\$ 1,070,853	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,203,090	\$ 1,300,471	48

Medina Nursing Center, Inc.
Provider #0011551
12/31/2006

Schedule 17A

**Schedule XV.
Balance Sheet**

Line 36 - Other Current Liabilities

	<u>Operating</u>	<u>After Consolidation</u>
Memorial Donations General	384	384
Memorial Donation Employee	673	673
Due to J Oksnevad	3,095	3,095
Payable - Employee Help Fund	24	24
Payable - 401k Retirement	2,553	2,553
Total	<u>\$ 6,729</u>	<u>\$ 6,729</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,081,636	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,081,636	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	50,729	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	(158,896)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	3	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (108,164)	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)	\$ 973,472	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,057,367	1
2	Discounts and Allowances for all Levels	79,783	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,137,150	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	410,319	6
7	Oxygen	17,268	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 427,587	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,136	13
14	Non-Patient Meals	12,431	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	75,605	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,218	19
20	Radiology and X-Ray		20
21	Other Medical Services	70,616	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 167,006	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	800	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 800	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	16,222	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 16,222	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,748,765	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	832,749	31
32	Health Care	1,723,874	32
33	General Administration	779,924	33
	B. Capital Expense		
34	Ownership	191,899	34
	C. Ancillary Expense		
35	Special Cost Centers	120,862	35
36	Provider Participation Fee	48,728	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,698,036	40
41	Income before Income Taxes (line 30 minus line 40)**	50,729	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 50,729	43

* 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.
This entity is a cash basis taxpayer.

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

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

Medina Nursing Center, Inc.
Provider #0011551
12/31/2006

Schedule 19A

Page 19
Schedule XVII
Income Statement

Line 28a - Other Revenue (specify):

	<u>Amount</u>
Vending Machine Income	9,414
Office Sales	196
Uniform Sales	6,335
Other Miscellaneous Sales	277
Total	<u>16,222</u>

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,080	\$ 60,997	\$ 29.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,036	11,809	243,066	20.58	3
4	Licensed Practical Nurses	6,197	6,588	130,395	19.79	4
5	CNAs & Orderlies	50,677	53,104	527,574	9.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,943	2,117	24,279	11.47	9
10	Activity Assistants	2,932	3,091	29,045	9.40	10
11	Social Service Workers	3,774	4,052	64,606	15.94	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	32,856	15.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,882	22,165	194,828	8.79	15
16	Dishwashers					16
17	Maintenance Workers	5,020	5,131	57,506	11.21	17
18	Housekeepers	6,897	7,467	78,043	10.45	18
19	Laundry	8,390	8,844	70,561	7.98	19
20	Administrator	3,120	3,120	150,212	48.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,960	2,080	33,600	16.15	23
24	Clerical	4,275	4,625	49,887	10.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,988	2,114	20,517	9.71	31
32	Other Health C: Care Plan Coord.	2,842	3,336	45,465	13.63	32
33	Other(specify) <u>Beautician</u>	1,030	1,120	11,325	10.11	33
34	TOTAL (lines 1 - 33)	136,923	144,923	\$ 1,824,762 *	\$ 12.59	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	129	\$ 5,486	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	827	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	6	445	11(3)	44
45	Social Service Consultant	8	580	12(3)	45
46	Other(specify) <u>Beautician</u>	1 day	171	40(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	143	\$ 13,509		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,111	\$ 42,083	10(3)	50
51	Licensed Practical Nurses	2,584	86,133	10(3)	51
52	Certified Nurse Assistants/Aides	3,999	83,623	10(3)	52
53	TOTAL (lines 50 - 52)	7,694	\$ 211,839		53

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center, Inc.
Provider #: 0011551
01/01/05 to 12/31/05

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	102,212
Non-Allowable Legal Fees	(12,526)
Total (agree to Schedule V, line 19, column 8)	<u>89,686</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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	Amount of Expense Amortized Per Year								
FY2003					FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2							N/A						
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center# 0011551Report Period Beginning: 01/01/06Ending: 12/31/06**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. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? N/A
- (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? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,429 Line 10
- (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. N/A
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,728
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 12,431
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
- 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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- 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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees