

Facility Name & ID Number Medina Nursing Center

0011551 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	3 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	Private Pay	4 Other		
8	SNF	362		2,067	2,429	8
9	SNF/PED					9
10	ICF	16,904	7,435		24,339	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,266	7,435	2,067	26,768	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.40%

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 Note: 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 2,067

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 01/01/2007 Fiscal Year: 12/31/2007
* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	241,001	27,374	6,341	274,716		274,716		274,716	1	
2	Food Purchase		192,637		192,637		192,637	(10,168)	182,469	2	
3	Housekeeping	94,981	24,722		119,703		119,703		119,703	3	
4	Laundry	75,012	6,080		81,092		81,092		81,092	4	
5	Heat and Other Utilities			89,606	89,606		89,606		89,606	5	
6	Maintenance	58,542	23,989	59,943	142,474		142,474		142,474	6	
7	Other (specify):*									7	
8	TOTAL General Services	469,536	274,802	155,890	900,228		900,228	(10,168)	890,060	8	
B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000	9	
10	Nursing and Medical Records	1,018,869	82,013	248,513	1,349,395		1,349,395		1,349,395	10	
10a	Therapy		2,309	288,435	290,744		290,744		290,744	10a	
11	Activities	46,739	3,497	11,533	61,769		61,769		61,769	11	
12	Social Services	71,031		6,791	77,822		77,822		77,822	12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):*									15	
16	TOTAL Health Care and Programs	1,136,639	87,819	561,272	1,785,730		1,785,730		1,785,730	16	
C. General Administration											
17	Administrative	138,558			138,558		138,558		138,558	17	
18	Directors Fees									18	
19	Professional Services			51,880	51,880		51,880	(8,301)	43,579	19	
20	Dues, Fees, Subscriptions & Promotions			28,227	28,227		28,227		28,227	20	
21	Clerical & General Office Expenses	88,656	28,301	13,914	130,871		130,871	(344)	130,527	21	
22	Employee Benefits & Payroll Taxes			327,110	327,110		327,110		327,110	22	
23	Inservice Training & Education			1,766	1,766		1,766		1,766	23	
24	Travel and Seminar			13,598	13,598		13,598	(2,928)	10,670	24	
25	Other Admin. Staff Transportation			8,045	8,045		8,045		8,045	25	
26	Insurance-Prop.Liab.Malpractice			13,032	13,032		13,032		13,032	26	
27	Other (specify):*									27	
28	TOTAL General Administration	227,214	28,301	457,572	713,087		713,087	(11,573)	701,514	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,833,389	390,922	1,174,734	3,399,045		3,399,045	(21,741)	3,377,304	29	

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Medina Nursing Center

#0011551

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
	Depreciation			81,580	81,580		81,580	36,441	118,021			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,927	3,927		3,927	(2,670)	1,257			32
33	Real Estate Taxes			46,917	46,917		46,917		46,917			33
34	Rent-Facility & Grounds			36,000	36,000		36,000	(36,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			168,424	168,424		168,424	(2,229)	166,195			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,000	1,000		1,000		1,000			38
39	Ancillary Service Centers			92,184	92,224		92,224		92,224			39
40	Barber and Beauty Shops	11,768	388		12,156		12,156		12,156			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,342	49,342		49,342		49,342			42
43	Other (specify):* Non-allowable Cos			48,090	48,090		48,090	(48,090)				43
44	TOTAL Special Cost Centers	11,768	92,572	98,472	202,812		202,812	(48,090)	154,722			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,845,157	483,494	1,441,630	3,770,281		3,770,281	(72,060)	3,698,221			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

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	(10,168)	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	29,555	30		9
10	Interest and Other Investment Income	(2,670)	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	(8,301)	43		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,639)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(16,949)	43		28
29	Other-Attach Schedule See Pg. 5A	(30,774)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (42,946)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	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)	(29,114)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (29,114)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (72,060)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center

ID# 0011551

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Labs Part A	\$ (6,487)	43	1
2	Disallow X-Rays	(1,252)	43	2
3	Offset Vending Machine Revenue	(5,957)	43	3
4	Disallow PAC Donations	(3,620)	24	4
5	Disallow Donations Expense	(1,849)	43	5
6	Disallow Apartment costs	(2,108)	43	6
7	Offset Insurance Other costs	(6,229)	43	7
8	Offset Income against related expense	(344)	21	8
9	Disallow Out of State travel	(2,928)	24	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	(30,774)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Medina Nursing Center# 0011551 Report Period Beginning:01/01/2007Ending: 12/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,168)	0	0	0	0	0	0	0	0	0	0	(10,168)	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	(10,168)	0	0	0	0	0	0	0	0	0	0	(10,168)	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	(344)	0	0	0	0	0	0	0	0	0	0	(344)	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	(6,548)	0	0	0	0	0	0	0	0	0	0	(6,548)	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	(6,892)	0	0	0	0	0	0	0	0	0	0	(6,892)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,060)	0	0	0	0	0	0	0	0	0	0	(17,060)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Medina Nursing Center# 0011551

Report Period Beginning:

01/01/2007 Ending:12/31/2007

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	29,555	6,886	0	0	0	0	0	0	0	0	0	36,441	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,670)	0	0	0	0	0	0	0	0	0	0	(2,670)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,000)	0	0	0	0	0	0	0	0	0	(36,000)	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	26,885	(29,114)	0	0	0	0	0	0	0	0	0	(2,229)	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):*	(52,771)	0	0	0	0	0	0	0	0	0	0	(52,771)	43
44	TOTAL Special Cost Centers	(52,771)	0	0	0	0	0	0	0	0	0	0	(52,771)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(42,946)	(29,114)	0	0	0	0	0	0	0	0	0	(72,060)	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	36,000	Medina Manor Building, Inc.			(36,000)	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		\$ 36,000			\$ 6,886	\$ * (29,114)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	\$ 138,558	L 17, 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	\$ 138,558		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: 01/01/2007

Ending: 2/31/2007

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

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: 01/01/2007 Ending: 12/31/2007

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	M & I Dealer Finance		X	Vehicle Loan	\$920.60	02/22/2004	\$ 55,236	\$ 11,691	01/22/2009	0.0399	\$ 692	1								
2	State Bank of Davis		X	Vehicle Loan	\$784.02	10/20/2005	40,070	21,737	9/20/2010	0.0650	1,806	2								
3												3								
4												4								
5												5								
	Working Capital																			
6	Durand State Bank		X	Working Capital	None	12/31/2002	Varies		03/31/2007	0.0675	1,429	6								
7												7								
8												8								
9	TOTAL Facility Related				\$1,704.62		\$ 95,306	\$ 33,428			\$ 3,927	9								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13							Disallow non-allowable interest expense				(2,670)	13								
14	TOTAL Non-Facility Related						\$	\$			\$ (2,670)	14								
15	TOTALS (line 9+line14)						\$ 95,306	\$ 33,428			\$ 1,257	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	45,000	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.)		2006		\$	44,917	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(83)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	47,000	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				\$	46,917	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2002	37,512	8	FOR BHF USE ONLY	
		2003	38,678	9	13	FROM R. E. TAX STATEMENT FOR 2006 \$ 13
		2004	41,267	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
		2005	42,836	11	15	LESS REFUND FROM LINE 6 \$ 15
		2006	44,917	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
2006 Estimated Tax paid	44,917					
Estimated Tax increase	1.04					
Total	46,714					
Use	47,000					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Medina Nursing Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0011551

CONTACT PERSON REGARDING THIS REPORT Holgeir Oksnevad

TELEPHONE (815) 248-2151 FAX #: (815) 248-2771

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>936.22</u>	\$ <u>936.22</u>
2. <u>05-15-251-002</u>	<u>Medina Manor Building</u>	\$ <u>43,023.74</u>	\$ <u>43,023.74</u>
3. <u>05-15-251-003</u>	<u>Medina Manor Building</u>	\$ <u>956.78</u>	\$ <u>956.78</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>44,916.74</u>	\$ <u>44,916.74</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,000 B. General Construction Type: Exterior Brick Frame Masonry, Fire Resistar 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:

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Bed*	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
5	25	1980	1980	158,173		30	5,272	5,272	147,777
6									
7									
8									
Improvement Type**									
9	Building Improvements		1968	675		15			675
10	Building Improvements		1974	861		10			861
11	Building Improvements		1975	1,547		10			1,547
12	Building Improvements		1976	345		9			345
13	Building Improvements		1977	12,614		21			12,614
14	Building Improvements		1977	2,793		8			2,793
15	Building Improvements		1979	2,620		7			2,620
16	Building Improvements		1980	24,465		20			24,465
17	Building Improvements		1980	2,137		7			2,137
18	Building Improvements		1981	20,211		15			20,211
19	Building Improvements		1982	2,305		20			2,305
20	Building Improvements		1983	705		5			705
21	Building Improvements		1985	980		10			980
22	Building Improvements		1985	3,091	103	20		(103)	3,091
23	Building Improvements		1986	17,543		10			17,543
24	Building Improvements		1987	56,373		20	1,412	1,412	56,373
25	Building Improvements		1988	14,212		20	711	711	13,857
26	Building Improvements		1989	30,063		20	1,503	1,503	27,807
27	Building Improvements		1990	1,601		20	80	80	1,404
28	Building Improvements		1991	51,619	1,147	20	2,581	1,434	42,586
29	Building Improvements		1991	11,626		20	581	581	9,008
30	Building Improvements		1992	39,070	2,605	20	1,954	(651)	28,331
31	Building Improvements		1992	3,295	203	20	165	(38)	2,555
32	Building Improvements		1992	19,372		20	969	969	15,017
33	Building Improvements		1992	23,809	2,362	20	1,190	(1,172)	18,445
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

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)	\$ 26,871	37
38	Building Improvements	1993	100,000		20	5,000	5,000	71,669	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	36,384	39
40	Building Improvements	1994	15,610		10			15,610	40
41	Building Improvements	1995	47,826	3,188	15	3,188		39,851	41
42	Building Improvements	1995	36,144	2,410	15	2,410		30,124	42
43	Outdoor Signs	1996	2,149	143	15	143		1,645	43
44	Backflow Preventors	1996	3,679	245	15	245		2,818	44
45	Garbage Disposal	1996	761	51	15	51		586	45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		1,774	46
47	Door	1997	1,996	133	15	133		1,397	47
48	Sign	1997	666	44	15	44		463	48
49	Air Conditioner	1997	3,500	233	15	233		2,447	49
50	Lights	1997	621	41	15	41		431	50
51	Driveway	1997	2,875	192	15	192		2,016	51
52	Fire Alarm	1997	1,246	83	15	83		872	52
53	Plumbing	1997	5,122	341	15	341		3,581	53
54	Telephone System	1997	1,152	77	15	77		784	54
55	Permanent Outdoor Receptacles	1997	585	39	15	39		410	55
56	Office Remodeling	1998	2,454	164	15	164		1,558	56
57	Exterior Doors	1998	7,652	510	15	510		4,845	57
58	Windows	1998	15,536	1,036	15	1,036		9,842	58
59	Roof Repair	1998	2,317	154	15	154		1,463	59
60	Water and Sewer Improvements	1998	3,165	211	15	211		2,003	60
61	Fire Alarm	1998	1,157	77	15	77		732	61
62	Telephone System	1998	1,467	98	15	98		929	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		\$ 35,605	\$ 13,859	\$ 1,205,801	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:

01/01/2007

Ending:

12/31/2007**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		\$ 35,605	\$ 13,859	\$ 1,205,801		1
2	Blinds	1999 3,689	246	15	246		2,089		2
3	Window Replacement	1999 5,145	305	15	343	38	2,916		3
4	Rewire & Replumb Laundry Room	1999 7,824	481	15	522	41	4,431		4
5	Floor Tile	1999 1,049	70	15	70		595		5
6	Air Conditioning	1999 1,895	126	15	126		1,071		6
7	Boiler	1999 535	36	15	36		300		7
8	Sidewalk	2000 1,386	92	15	92		690		8
9	Kickplates	2000 608	41	15	41		302		9
10	Landscaping Brick	2000 1,139	76	15	76		570		10
11	Blacktop Parking Lot	2001 15,000	1,000	15	1,000		6,500		11
12	Dumpster Gate Frames	2001 1,650	110	15	110		715		12
13	Dumpster Concrete Platform	2001 3,700	247	15	247		1,605		13
14	Stone Wall	2001 1,665	111	15	111		721		14
15	Video Surveillance	2002 14,865	991	15	991		5,451		15
16	Wrought Iron Fence	2002 5,105	340	15	340		1,870		16
17	Nurses Call System	2002 12,726	848	15	848		4,664		17
18	Custom Doors	2002 9,427	628	15	628		3,454		18
19	Windows Framing	2003 11,656	777	15	777		3,497		19
20	Roof	2003 7,470	498	15	498		2,241		20
21	Alarm Installation	2003 12,730	849	15	849		3,820		21
22	Cabinets	2004 504	34	15	34		119		22
23	Surveillance Cameras	2004 578	39	15	39		135		23
24	Time Clock	2004 10,000	667	15	667		2,333		24
25	Latches	2004 8,923	595	15	595		2,081		25
26	Exhaust Hood	2004 4,290	286	15	286		1,001		26
27	Bath Call Light	2004 1,229	82	15	82		287		27
28	Ventilator	2004 1,038	69	15	69		243		28
29	Driveway	2004 4,000	267	15	267		933		29
30	Sidewalk & Driveway	2005 5,209	347	15	347		867		30
31	Wiring & Outlets	2005 8,903	594	15	594		1,484		31
32	Windows	2005 1,911	127	15	127		318		32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,507,769	\$ 32,725		\$ 46,663	\$ 13,938	\$ 1,263,104		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	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	\$ 1,507,769	\$ 32,725		\$ 46,663	\$ 13,938	\$ 1,263,104		1
2	Flag Poles	2005 4,362	291	15	291		727		2
3									3
4	Fire Alarm System	2006 12,455	415	15	830	415	1,245		4
5	Doors and Gaskets	2006 6,545	218	15	436	218	654		5
6	Water Softner	2006 965	32	15	64	32	96		6
7	Landscaping Improvements	2006 2,377	79	15	158	79	237		7
8	Timeclock	2006 20,715	691	15	1,382	691	2,073		8
9	Roofing	2006 1,350	45	15	90	45	135		9
10	Fire Door	2006 965	32	15	64	32	95		10
11	Hot Water Storage Tank	2006 11,998	400	15	800	400	1,200		11
12	A/C Compressor	2006 1,777	59	15	118	59	177		12
13	Fire Alarm Panel	2006 3,200	107	15	214	107	321		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21	Roofing	2007 2,675	89	15	89		89		21
22	Fire Safety Doors	2007 3,111	104	15	104		104		22
23	Kitchen Cabinets	2007 4,131	138	15	138		138		23
24	Water Treatment System	2007 11,465	382	15	382		382		24
25									25
26	Timeclock system	2007 4,034	134	15	134		134		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 1,599,894	\$ 35,941		\$ 51,957	\$ 16,016	\$ 1,270,911		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	\$ 307,327	\$ 21,906	\$ 29,744	\$ 7,838	5-10	\$ 206,129	71
72	Current Year Purchases	47,233	3,447	5,617	2,170	10	5,617	72
73	Fully Depreciated Assets	63,829					63,829	73
74								74
75	TOTALS	\$ 418,389	\$ 25,353	\$ 35,361	\$ 10,008		\$ 275,575	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	\$	\$	\$		\$ 9,409	76
77	Resident Van	1991 Chevy Lumina	1991	18,008					18,008	77
78	Activity Bus	1998 Ford Bus	1998	49,705					49,705	78
79	Schedule 13A			153,518	20,286	30,703	10,417		98,663	79
80	TOTALS			\$ 230,640	\$ 20,286	\$ 30,703	\$ 10,417		\$ 175,785	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)	\$ 2,251,971	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,580	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 118,021	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 36,441	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,722,271	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center

Provider #: 0011551

1/1/2007 to 12/31/2007

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	2,143	6,000	(3,857)	5	27,858
Maintenance	2004 F250 Ford Picku	2004	51,020	3,644	10,204	(6,560)	5	34,557
Maintenance	2005 Ford Freestar	2005	8,436	1,687	1,687	-	5	4,218
Administrative	2006 Mercedes	2005	64,062	12,812	12,812	-	5	32,030
TOTAL			\$153,518	\$20,286	\$30,703	(\$10,417)		\$98,663

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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

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>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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 N/A.

N/A

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					18
19			<u>N/A</u>		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.

SEE ACCOUNTANTS' COMPILATION REPORT

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 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			
	1	2	3	4
	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.)

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
1	Licensed Occupational Therapist	10A(3)	1821	hrs	\$ 109,270		\$	1,821	\$ 109,270	1
2	Licensed Speech and Language Development Therapist	10A(3)	800	hrs	47,980			800	47,980	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	10A(3)	2186	hrs	131,185		2,309	2,186	133,494	4
5	Physician Care			visits						5
6	Dental Care	39(3)	1	visits	40			1	40	6
7	Work Related Program			hrs						7
8	Habilitation			hrs						8
9	Pharmacy	39(2)		# of prescripts			92,184		92,184	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				\$ 288,475		\$ 94,493	4,808	\$ 382,968	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

0011551

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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	\$ 44,598	\$ 45,372	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	442,269	442,269	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	12,623	12,623	6
7 Other Prepaid Expenses	43,868	43,868	7
8 Accounts Receivable (owners or related parties)	57,000	57,000	8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 600,358	\$ 601,132	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 Cos	751,844	953,077	15
16 Equipment, at Historical Cost	692,503	649,029	16
17 Accumulated Depreciation (book methods)	(1,003,022)	(1,722,271)	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
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 441,325	\$ 529,700	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,041,683	\$ 1,130,832	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 47,311	\$ 47,311	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	20,738	20,738	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	55,347	55,347	30
31 Accrued Taxes Payable (excluding real estate taxes)	16,210	16,210	31
32 Accrued Real Estate Taxes(Sch.IX-B)	47,000	47,000	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	4,955	4,955	36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 191,561	\$ 191,561	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	33,428	33,428	39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 33,428	\$ 33,428	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 224,989	\$ 224,989	46
47 TOTAL EQUITY (page 18, line 24)	\$ 816,694	\$ 905,843	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,041,683	\$ 1,130,832	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Medina Nursing Center, Inc.
Provider # 0011551
12/31/2007

Schedule 17A

Schedule XV
Balance Sheet

Line 36- Other Current Liabilities

	Operating	After Consolidation
Memorial Donations General	384.00	384.00
Memorial Donations Employees	673.00	673.00
Due to J Oksnevad	3,095.00	3,095.00
Payable- 401k Retirement	803.00	803.00
	<u>4,955.00</u>	<u>4,955.00</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 973,472	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 973,472	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	37,833	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	(194,611)	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)	\$ (156,778)	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)	\$ 816,694	24 *

* 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	\$ 3,149,866	1
2	Discounts and Allowances for all Levels	70,913	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,220,779	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	389,245	6
7	Oxygen	5,949	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 395,194	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	7,586	13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	90,201	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,791	19
20	Radiology and X-Ray		20
21	Other Medical Services	62,807	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 165,385	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,670	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,670	26
E. Other Revenue (specify):****			
27			27
28	See Schedule 19A	1,406	28
28a	See Schedule 19A	22,680	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 24,086	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,808,114	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	900,228	31
32	Health Care	1,785,730	32
33	General Administration	713,087	33
B. Capital Expense			
34	Ownership	168,424	34
C. Ancillary Expense			
35	Special Cost Centers	153,470	35
36	Provider Participation Fee	49,342	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,770,281	40
41	Income before Income Taxes (line 30 minus line 40)**	37,833	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 37,833	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
12/31/2007

Schedule 19A

Schedule XVII
Income Statement

Line 28- Other Revenues

	Amount
Miscellaneous Sales	217.00
Memorial Donations	<u>1,189.00</u>
	<u><u>1,406.00</u></u>

Line 28A- Other Revenues

	Amount
Vending Machine Income	6,793.00
Uniform Sales	5,132.00
Other Misc Sales	<u>10,755.00</u>
	<u><u>22,680.00</u></u>

Facility Name & ID Number Medina Nursing Center

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	2,080	2,080	\$ 63,094	\$ 30.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,451	11,423	275,975	24.16	3
4	Licensed Practical Nurses	6,527	7,028	166,291	23.66	4
5	CNAs & Orderlies	45,130	47,018	475,566	10.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,991	2,132	25,001	11.73	9
10	Activity Assistants	2,313	2,442	21,738	8.90	10
11	Social Service Workers	3,973	4,126	71,031	17.22	11
12	Dietician					12
13	Food Service Supervisor	2,120	2,120	34,146	16.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,246	22,483	206,855	9.20	15
16	Dishwashers					16
17	Maintenance Workers	4,986	5,138	58,542	11.39	17
18	Housekeepers	7,724	8,280	94,981	11.47	18
19	Laundry	8,467	8,891	75,012	8.44	19
20	Administrator	3,120	3,120	138,558	44.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	34,676	16.67	23
24	Clerical	4,608	4,892	53,980	11.03	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	1,894	2,090	21,108	10.10	31
32	Other Health Care Coord.	1,100	1,226	16,835	13.73	32
33	Other(specify) <u>Beautician</u>	1,078	1,161	11,768	10.14	33
34	TOTAL (lines 1 - 33)	130,888	137,730	\$ 1,845,157 *	\$ 13.40	34

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	129	\$ 6,341	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	802	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	14	1,012	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	154	\$ 14,155		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	295	\$ 12,739	10 (3)	50
51	Licensed Practical Nurses	900	32,389	10 (3)	51
52	Certified Nurse Assistants/Aides	9,572	196,088	10 (3)	52
53	TOTAL (lines 50 - 52)	10,767	\$ 241,216		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

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	
Holgeir Oksnevad	Administrator	100	\$ 138,558	Workers' Compensation Insurance	\$ 50,086	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	15,336	Advertising: Employee Recruitment	23,317	
				FICA Taxes	133,415	Health Care Worker Background Check	1,392	
				Employee Health Insurance	72,577	(Indicate # of checks performed <u>116</u>)		
				Employee Meals		Patient Background Checks	11 137	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	1,292	
				Employee Uniforms	5,929	Miscellaneous Dues & Subscriptions	1,094	
				Employee Retirement	39,430			
				Employee Relations	6,752			
				Employee Physicals	3,585			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 138,558	TOTAL (agree to Schedule V, line 22, col.8)	\$ 327,110	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 28,227	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$		
				N/A			Out-of-State Travel	\$
							In-State Travel	5,299
							Seminar Expense	5,371
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 10,670
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
RSM McGladrey	Accounting		\$ 208					
McGladrey & Pullen	Accounting		8,871					
Duane Morris	Legal		13,071					
eHealth Data Solutions	Computer Services		3,375					
Business Management Services	Computer Services		13,674					
Mediacom	Computer Services		1,204					
Mutual Omaha	Computer Services		92					
Achieve Healthcare Tech	Computer Services		6,654					
Chase Card Services	Computer Services		150					
Amberbeaty Computer	Computer Services		600					
Dresser Associates	Computer Services		2,253					
Uniftime Systems	Computer Services		1,728					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 51,880					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4							N/A					
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: 01/01/2007Ending: 12/31/2007**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 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? No
- (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? 10-15 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,297 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. \$ 49,342
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,168
- (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? N/A 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 \$5,000, have legal invoices and a summary of service performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT