



Facility Name & ID Number Medina Nursing Center

# 0011551 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	32,574	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	32,574	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	16,567	8,436	2,284	27,287	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,567	8,436	2,284	27,287	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.77%

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 2,284

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

**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
	<b>A. General Services</b>										
1	Dietary	254,494	22,128	6,911	283,533		283,533		283,533		1
2	Food Purchase		226,930		226,930		226,930	(8,071)	218,859		2
3	Housekeeping	99,971	32,974		132,945		132,945		132,945		3
4	Laundry	82,214	8,597		90,811		90,811		90,811		4
5	Heat and Other Utilities			110,046	110,046		110,046		110,046		5
6	Maintenance	66,072	21,155	71,243	158,470		158,470		158,470		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	502,751	311,784	188,200	1,002,735		1,002,735	(8,071)	994,664		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,100	7,100		7,100		7,100		9
10	Nursing and Medical Records	1,113,308	95,578	222,831	1,431,717		1,431,717		1,431,717		10
10a	Therapy		3,982	311,494	315,476		315,476		315,476		10a
11	Activities	43,406	4,137	12,786	60,329		60,329		60,329		11
12	Social Services	77,874		6,014	83,888		83,888		83,888		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,234,588	103,697	560,225	1,898,510		1,898,510		1,898,510		16
	<b>C. General Administration</b>										
17	Administrative	138,915			138,915		138,915		138,915		17
18	Directors Fees										18
19	Professional Services			53,749	53,749		53,749	(3,295)	50,454		19
20	Dues, Fees, Subscriptions & Promotions			22,579	22,579		22,579		22,579		20
21	Clerical & General Office Expenses	123,912	16,555	9,955	150,422		150,422	(826)	149,596		21
22	Employee Benefits & Payroll Taxes			381,600	381,600		381,600	(5,441)	376,159		22
23	Inservice Training & Education										23
24	Travel and Seminar			15,730	15,730		15,730		15,730		24
25	Other Admin. Staff Transportation			8,736	8,736		8,736		8,736		25
26	Insurance-Prop.Liab.Malpractice			3,741	3,741		3,741		3,741		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	262,827	16,555	496,090	775,472		775,472	(9,562)	765,910		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,000,166	432,036	1,244,515	3,676,717		3,676,717	(17,633)	3,659,084		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:

01/01/2008

Ending:

12/31/2008

## 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	
	<b>D. Ownership</b>											
30	Depreciation			82,506	82,506		82,506	44,638	127,144			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,357	4,357		4,357	(1,125)	3,232			32
33	Real Estate Taxes			46,996	46,996		46,996		46,996			33
34	Rent-Facility & Grounds			36,000	36,000		36,000	(36,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			169,859	169,859		169,859	7,513	177,372			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			1,814	1,814		1,814		1,814			38
39	Ancillary Service Centers		90,021		90,021		90,021		90,021			39
40	Barber and Beauty Shops	11,613	196		11,809		11,809		11,809			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,862	48,862		48,862		48,862			42
43	Other (specify):* <b>Non-allowable cost</b>			59,529	59,529		59,529	(59,956)	(427)			43
44	<b>TOTAL Special Cost Centers</b>	11,613	90,217	110,205	212,035		212,035	(59,956)	152,079			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,011,779	522,253	1,524,579	4,058,611		4,058,611	(70,076)	3,988,535			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	(8,071)	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	39,570	30		9
10	Interest and Other Investment Income	(1,125)	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	(4,702)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,794)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(9,539)	43		28
29	Other-Attach Schedule See PG. 5A	(49,483)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (39,144)		\$	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)	(30,932)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (30,932)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (70,076)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center

ID# 0011551

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs - Part A	\$ (2,723)	43	1
2	X-Rays - Part A	(2,292)	43	2
3	Disallow Vending costs	(3,464)	43	3
4	Offset cable TV revenue	(4,287)	43	4
5	IDPH Sanctions	(1,000)	43	5
6	Disallow PAC donations	(5,384)	43	6
7	Disallow Donations expense	(1,067)	43	7
8	Disallow apartment costs	(1,329)	43	8
9	Offset Insurance other costs	(6,722)	43	9
10	Offset office income against expense	(826)	21	10
11	Offset employee uniform income	(5,441)	22	11
12	Offset vending machine revenue	(6,098)	43	12
13	Disallow non-allowable legal	(3,295)	19	13
14	Disallow gain/loss on disposal of asset	(5,555)	43	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	<b>Total</b>	(49,483)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Medina Nursing Center# 0011551

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	(8,071)	0	0	0	0	0	0	0	0	0	0	(8,071)	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	<b>TOTAL General Services</b>	<b>(8,071)</b>	<b>0</b>	<b>(8,071)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(3,295)	0	0	0	0	0	0	0	0	0	0	(3,295)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(826)	0	0	0	0	0	0	0	0	0	0	(826)	21
22	Employee Benefits & Payroll Taxes	(5,441)	0	0	0	0	0	0	0	0	0	0	(5,441)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(9,562)</b>	<b>0</b>	<b>(9,562)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(17,633)</b>	<b>0</b>	<b>(17,633)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Medina Nursing Center# 0011551

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	39,570	5,068	0	0	0	0	0	0	0	0	0	44,638	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,125)	0	0	0	0	0	0	0	0	0	0	(1,125)	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	<b>TOTAL Ownership</b>	<b>38,445</b>	<b>(30,932)</b>	<b>0</b>	<b>7,513</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(59,956)	0	0	0	0	0	0	0	0	0	0	(59,956)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(59,956)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(59,956)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(39,144)</b>	<b>(30,932)</b>	<b>0</b>	<b>(70,076)</b>	<b>45</b>								

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.		\$ 5,068	\$ 5,068	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			\$ 5,068	\$ * (30,932)	14

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

Facility Name &amp; ID Number

Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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	\$ 138,915	17(1)	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 138,915		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: 01/01/2008 Ending: 2/31/2008

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			N/A						5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

## 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			
	<b>A. Directly Facility Related</b>																	
	<b>Long-Term</b>																	
1	M & I Dealer Finance		X	Vehicle Loan	\$920.60	02/22/2004	\$ 55,236	\$ 6,115	01/22/2009	0.0399	\$ 1,297	1						
2	State Bank of Davis		X	Vehicle Loan	\$784.02	10/20/2005	40,070	915	9/20/2010	0.0650	271	2						
3												3						
4												4						
5												5						
	<b>Working Capital</b>																	
6	Durand State Bank		X	Working Capital	None	12/31/2002	Varies	188,869	03/31/2009	0.0675	2,789	6						
7	J. Oksnevad	X		Working Capital	None	Varies	Varies	3,095	Demand	None		7						
8												8						
9	<b>TOTAL Facility Related</b>				\$1,704.62		\$ 95,306	\$ 198,994			\$ 4,357	9						
	<b>B. Non-Facility Related*</b>																	
10												10						
11												11						
12												12						
13							Interest income offset				(1,125)	13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (1,125)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 95,306	\$ 198,994			\$ 3,232	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**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<b>47,000</b>	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.)	2007	\$	<b>45,996</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,004)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>48,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>46,996</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>38,678</b>	8
	2004	<b>41,267</b>	9
	2005	<b>42,836</b>	10
	2006	<b>44,917</b>	11
	2007	<b>45,996</b>	12
<b>2007 Estimated Tax paid</b>	<b>45,996</b>		
<b>Estimated Tax increase</b>	<b>1.04</b>		
<b>Total</b>	<b>47,835</b>		
<b>Use</b>	<b>48,000</b>		

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>958.68</u>	\$ <u>958.68</u>
2. <u>05-15-251-002</u>	<u>Medina Manor Building</u>	\$ <u>44,057.72</u>	\$ <u>44,057.72</u>
3. <u>05-15-251-003</u>	<u>Medina Manor Building</u>	\$ <u>979.78</u>	\$ <u>979.78</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>45,996.18</u>	\$ <u>45,996.18</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        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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2008 Ending:

12/31/2008

**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: N/A

(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	<b>TOTALS</b>			<b>\$ 3,048</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	153,049	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
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		20			3,091	22
23	Building Improvements		1986	17,543		10			17,543	23
24	Building Improvements		1987	56,373		20			56,373	24
25	Building Improvements		1988	14,212		20	355	355	14,212	25
26	Building Improvements		1989	30,063		20	1,503	1,503	29,310	26
27	Building Improvements		1990	1,601		20	80	80	1,484	27
28	Building Improvements		1991	51,619	1,147	20	2,581	1,434	45,167	28
29	Building Improvements		1991	11,626		20	581	581	9,589	29
30	Building Improvements		1992	39,070	2,605	20	1,954	(651)	30,285	30
31	Building Improvements		1992	3,295	203	20	165	(38)	2,720	31
32	Building Improvements		1992	19,372		20	969	969	15,986	32
33	Building Improvements		1992	23,809	2,362	20	1,190	(1,172)	19,635	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 &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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)	\$ 28,724	37
38	Building Improvements	1993	100,000		20	5,000	5,000	76,669	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	39,079	39
40	Building Improvements	1994	15,610		10			15,610	40
41	Building Improvements	1995	47,826	3,188	15	3,188		43,039	41
42	Building Improvements	1995	36,144	2,410	15	2,410		32,534	42
43	Outdoor Signs	1996	2,149	143	15	143		1,788	43
44	Backflow Preventors	1996	3,679	245	15	245		3,063	44
45	Garbage Disposal	1996	761	51	15	51		637	45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		1,943	46
47	Door	1997	1,996	133	15	133		1,530	47
48	Sign	1997	666	44	15	44		507	48
49	Air Conditioner	1997	3,500	233	15	233		2,680	49
50	Lights	1997	621	41	15	41		472	50
51	Driveway	1997	2,875	192	15	192		2,208	51
52	Fire Alarm	1997	1,246	83	15	83		955	52
53	Plumbing	1997	5,122	341	15	341		3,922	53
54	Telephone System	1997	1,152	77	15	77		861	54
55	Permanent Outdoor Receptacles	1997	585	39	15	39		449	55
56	Office Remodeling	1998	2,454	164	15	164		1,722	56
57	Exterior Doors	1998	7,652	510	15	510		5,355	57
58	Windows	1998	15,536	1,036	15	1,036		10,878	58
59	Roof Repair	1998	2,317	154	15	154		1,617	59
60	Water and Sewer Improvements	1998	3,165	211	15	211		2,214	60
61	Fire Alarm	1998	1,157	77	15	77		809	61
62	Telephone System	1998	1,467	98	15	98		1,027	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,341,920	\$ 21,643		\$ 33,837	\$ 12,194	\$ 1,239,638	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,341,920	\$ 21,643		\$ 33,837	\$ 12,194	\$ 1,239,638	1
2	Blinds	1999	3,689	246	15	246		2,335	2
3	Window Replacement	1999	5,145	305	15	343	38	3,259	3
4	Rewire & Replumb Laundry Room	1999	7,824	481	15	522	41	4,953	4
5	Floor Tile	1999	1,049	70	15	70		665	5
6	Air Conditioning	1999	1,895	126	15	126		1,197	6
7	Boiler	1999	535	36	15	36		336	7
8	Sidewalk	2000	1,386	92	15	92		782	8
9	Kickplates	2000	608	41	15	41		343	9
10	Landscaping Brick	2000	1,139	76	15	76		646	10
11	Blacktop Parking Lot	2001	15,000	1,000	15	1,000		7,500	11
12	Dumpster Gate Frames	2001	1,650	110	15	110		825	12
13	Dumpster Concrete Platform	2001	3,700	247	15	247		1,852	13
14	Stone Wall	2001	1,665	111	15	111		832	14
15	Video Surveillance	2002	14,865	991	15	991		6,442	15
16	Wrought Iron Fence	2002	5,105	340	15	340		2,210	16
17	Nurses Call System	2002	12,726	848	15	848		5,512	17
18	Custom Doors	2002	9,427	628	15	628		4,082	18
19	Windows Framing	2003	11,656	777	15	777		4,274	19
20	Roof	2003	7,470	498	15	498		2,739	20
21	Alarm Installation	2003	12,730	849	15	849		4,669	21
22	Cabinets	2004	504	34	15	34		153	22
23	Surveillance Cameras	2004	578	39	15	39		174	23
24	Time Clock	2004	10,000	667	15	667		3,000	24
25	Latches	2004	8,923	595	15	595		2,676	25
26	Exhaust Hood	2004	4,290	286	15	286		1,287	26
27	Bath Call Light	2004	1,229	82	15	82		369	27
28	Ventilator	2004	1,038	69	15	69		312	28
29	Driveway	2004	4,000	267	15	267		1,200	29
30	Sidewalk & Driveway	2005	5,209	347	15	347		1,214	30
31	Wiring & Outlets	2005	8,903	594	15	594		2,078	31
32	Windows	2005	1,911	127	15	127		445	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,507,769	\$ 32,622		\$ 44,895	\$ 12,273	\$ 1,307,999	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**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	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,507,769	\$ 32,622		\$ 44,895	\$ 12,273	\$ 1,307,999	1
2	Flag Poles	2005	4,362	291	15	291		1,018	2
3									3
4	Fire Alarm System	2006	12,455	415	15	830	415	2,075	4
5	Doors and Gaskets	2006	6,545	218	15	436	218	1,090	5
6	Water Softner	2006	965	32	15	64	32	160	6
7	Landscaping Improvements	2006	2,377	79	15	158	79	395	7
8	Timeclock	2006	20,715	691	15	1,382	691	3,455	8
9	Roofing	2006	1,350	45	15	90	45	225	9
10	Fire Door	2006	965	32	15	64	32	159	10
11	Hot Water Storage Tank	2006	11,998	400	15	800	400	2,000	11
12	A/C Compressor	2006	1,777	59	15	118	59	295	12
13	Fire Alarm Panel	2006	3,200	107	15	214	107	535	13
14									14
15	Roofing	2007	2,675	178	15	178		267	15
16	Fire Safety Doors	2007	3,111	207	15	207		311	16
17	Kitchen Cabinets	2007	4,131	275	15	275		413	17
18	Water Treatment System	2007	11,465	764	15	764		1,146	18
19	Timeclock system	2007	4,034	269	15	269		403	19
20									20
21	Sprinkler	2008	33,686	1,123	15	1,123		1,123	21
22	Tub room improvements	2008	20,275	676	15	676		676	22
23	Generator	2008	44,840	1,495	15	1,495		1,495	23
24	Wiring	2008	12,182	406	15	406		406	24
25	Pipe Insulation	2008	6,807	227	15	227		227	25
26	Fire Stops	2008	4,368	146	15	146		146	26
27	Sidewalk replacement	2008	4,805	160	15	160		160	27
28	Dining Room Doors	2008	8,397	280	15	280		280	28
29	Ceiling work	2008	4,374	146	15	146		146	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,739,628	\$ 41,343		\$ 55,694	\$ 14,351	\$ 1,326,605	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	\$ 354,560	\$ 16,730	\$ 40,978	\$ 24,248	5-10	\$ 252,724	71
72	Current Year Purchases	72,545	3,627	3,627		10	3,627	72
73	Fully Depreciated Assets	63,829					63,829	73
74								74
75	TOTALS	\$ 490,933	\$ 20,357	\$ 44,605	\$ 24,248		\$ 320,180	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	26,845	6,559		125,508	79
80	TOTALS			\$ 230,640	\$ 20,286	\$ 26,845	\$ 6,559		\$ 202,630	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)	\$ 2,464,249	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,986	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 127,144	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 45,158	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,849,415	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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**

**1/1/2008 to 12/31/2008**

**Schedule 13A**

**XI. Ownership Costs**

**Line 79 - Vehicle Depreciation**

<b>Use</b>	<b>Model, Make &amp; Year</b>	<b>Year Acquired</b>	<b>Cost</b>	<b>Current Book Depreciation</b>	<b>Straight Line Depreciation</b>	<b>Adjustments</b>	<b>Life in Years</b>	<b>Accumulated Depreciation</b>
Administrative	2002 Jeep Liberty	2002	30,000	2,143	2,142	1	5	30,000
Maintenance	2004 F250 Ford Pic	2004	51,020	3,644	10,204	(6,560)	5	44,761
Maintenance	2005 Ford Freestar	2005	8,436	1,687	1,687	-	5	5,905
Administrative	2006 Mercedes	2005	64,062	12,812	12,812	-	5	44,842
<b>TOTAL</b>			<b>\$153,518</b>	<b>\$20,286</b>	<b>\$26,845</b>	<b>(\$6,559)</b>		<b>\$125,508</b>

**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					18
19			<u>N/A</u>		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. /2009 \$ \_\_\_\_\_

13. /2010 \$ \_\_\_\_\_

14. /2011 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (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	\$	2,083	\$ 124,950	\$	2,083	\$ 124,950	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		323	19,407		323	19,407	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)(3)	hrs		2,786	167,137	3,982	2,786	171,119	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				90,021		90,021	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	5,192	\$ 311,494	\$ 94,003	5,192	\$ 405,497	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 12/31/2008

Report Period Beginning: 01/01/2008  
 (last day of reporting year)

Ending: 12/31/2008

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 8,335	\$ 9,290	1
2	Cash-Patient Deposits	21,053	21,053	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 55,000 )	815,094	815,094	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,882	8,882	6
7	Other Prepaid Expenses	23,130	23,130	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Notes due from Apartments</u>	78,500	78,500	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 954,994	\$ 955,949	10
	<b>B. Long-Term Assets</b>			
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	882,697	1,092,811	15
16	Equipment, at Historical Cost	766,106	721,573	16
17	Accumulated Depreciation (book methods)	(1,082,110)	(1,849,415)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 566,693	\$ 614,834	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,521,687	\$ 1,570,783	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 185,585	\$ 185,585	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	19,977	19,977	28
29	Short-Term Notes Payable	12,503	12,503	29
30	Accrued Salaries Payable	71,553	71,553	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,000	48,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37	<u>Payroll Liabilities</u>	3,586	3,586	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 341,204	\$ 341,204	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	186,491	186,491	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 186,491	\$ 186,491	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 527,695	\$ 527,695	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 993,992	\$ 1,043,088	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,521,687	\$ 1,570,783	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>816,694</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>816,694</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	349,766	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(172,466)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	(2)	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>177,298</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>993,992</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,663,284	1
2	Discounts and Allowances for all Levels	(854,552)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,808,732	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	365,388	6
7	Oxygen	7,312	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 372,700	8
	<b>C. Other Operating Revenue</b>		
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	7,408	13
14	Non-Patient Meals	8,071	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	99,309	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,719	19
20	Radiology and X-Ray		20
21	Other Medical Services	79,392	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 198,899	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	1,125	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,125	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Memorial Donations</b>	14,093	28
28a	<b>See Schedule 19A</b>	12,828	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 26,921	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,408,377	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,002,735	31
32	Health Care	1,898,510	32
33	General Administration	775,472	33
	<b>B. Capital Expense</b>		
34	Ownership	169,859	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	163,173	35
36	Provider Participation Fee	48,862	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,058,611	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	349,766	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 349,766	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**  
**12/31/2008**

**Schedule 19A**

**Schedule XVII**  
**Income Statement**

**Line 28A- Other Revenues**

	<b>Amount</b>
Pop Sales	4,534.00
Candy Sales	1,888.00
Office Sales	62.00
Uniform Sales	5,580.00
Miscellaneous Sales	48.00
Anything Else Sales	716.00
	<u>12,828.00</u>
	<u><u>12,828.00</u></u>

Facility Name & ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

**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	\$ 64,720	\$ 31.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,042	9,846	246,158	25.00	3
4	Licensed Practical Nurses	5,842	6,179	138,042	22.34	4
5	CNAs & Orderlies	49,747	51,767	539,952	10.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,260	4,491	43,406	9.67	10
11	Social Service Workers	3,946	4,197	77,874	18.55	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	35,696	17.16	13
14	Head Cook	3,977	4,348	61,172	14.07	14
15	Cook Helpers/Assistants	18,002	18,888	157,626	8.35	15
16	Dishwashers					16
17	Maintenance Workers	5,395	5,603	66,072	11.79	17
18	Housekeepers	8,185	8,626	99,971	11.59	18
19	Laundry	8,739	9,256	82,214	8.88	19
20	Administrator	3,000	3,120	138,915	44.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,950	9,656	123,912	12.83	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	1,964	2,100	22,069	10.51	31
32	Other Health Care(specify)	3,789	4,202	102,367	24.36	32
33	Other(specify) <u>Beautician</u>	1,048	1,141	11,613	10.18	33
34	TOTAL (lines 1 - 33)	139,846	147,580	\$ 2,011,779 *	\$ 13.63	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	141	\$ 6,911	1(3)	35
36	Medical Director	Monthly	7,100	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	3,063	10(3)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	708	11(3)	44
45	Social Service Consultant	14	1,012	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	165	\$ 18,794		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	575	\$ 24,724	10 (3)	50
51	Licensed Practical Nurses	1,194	42,989	10 (3)	51
52	Certified Nurse Assistants/Aides	7,603	152,055	10 (3)	52
53	TOTAL (lines 50 - 52)	9,372	\$ 219,768		53

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center

Provider #: 0011551

01/01/08 - 12/31/08

Schedule 20A

XVIII. Staffing & Salary Cost	Hours Wrkd	Hours Pd	Total Wages	Avg Hrly Wage
Line 32 - Other Healthcare				
Restorative Nurse	2,099	2,306	50,682	21.98
Care Plan Coordinator	1,690	1,896	51,685	27.26
	<u>3,789</u>	<u>4,202</u>	<u>102,367</u>	<u>49.24</u>

SEE ACCOUNTANTS' COMPILATION REPORT



Medina Nursing Center

Provider #: 0011551

01/01/08 - 12/31/08

Schedule 21A

<b>TOTAL (agree to Schedule V, line 19, column 3)</b>	53,749.00
Less: Disallowed legal	(3,295.00)
<b>TOTAL (agree to Schedule V, line 19, column 8)</b>	<u>50,454.00</u>

**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	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center# 0011551Report Period Beginning: 01/01/2008Ending: 12/31/2008**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? Yes  
If YES, give association name and amount. IHCA - \$9,334
- (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? 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? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,806 Line 10(2)
- (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. \$ 48,862  
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. \$ 8,071
- (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? N/A  
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? N/A  
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 services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees