

Facility Name & ID Number Medina Nursing Center

0011551 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	89	Skilled (SNF)	89	32,485	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,485	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	15,549	8,116	2,568	26,233	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	15,549	8,116	2,568	26,233	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.75%

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 2,568

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

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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	257,396	22,514	7,955	287,865		287,865		287,865		1
2	Food Purchase		211,823		211,823		211,823	(3,878)	207,945		2
3	Housekeeping	113,586	36,539		150,125		150,125		150,125		3
4	Laundry	71,007	9,730		80,737		80,737		80,737		4
5	Heat and Other Utilities			99,523	99,523		99,523		99,523		5
6	Maintenance	61,169	19,606	87,905	168,680		168,680		168,680		6
7	Other (specify):*										7
8	TOTAL General Services	503,158	300,212	195,383	998,753		998,753	(3,878)	994,875		8
	B. Health Care and Programs										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	1,121,695	107,376	211,364	1,440,435		1,440,435		1,440,435		10
10a	Therapy		3,886	393,661	397,547		397,547		397,547		10a
11	Activities	54,662	2,327	16,590	73,579		73,579	(15,630)	57,949		11
12	Social Services	81,777		8,277	90,054		90,054	(7,771)	82,283		12
13	CNA Training		12,191	37,151	49,342		49,342		49,342		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,258,134	125,780	682,643	2,066,557		2,066,557	(23,401)	2,043,156		16
	C. General Administration										
17	Administrative	151,408			151,408		151,408		151,408		17
18	Directors Fees										18
19	Professional Services			76,485	76,485		76,485		76,485		19
20	Dues, Fees, Subscriptions & Promotions			11,513	11,513		11,513		11,513		20
21	Clerical & General Office Expenses	135,025	17,929	9,795	162,749		162,749	(825)	161,924		21
22	Employee Benefits & Payroll Taxes			405,229	405,229		405,229	(5,166)	400,063		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,917	11,917		11,917		11,917		24
25	Other Admin. Staff Transportation			6,025	6,025		6,025		6,025		25
26	Insurance-Prop.Liab.Malpractice			15,812	15,812		15,812		15,812		26
27	Other (specify):*										27
28	TOTAL General Administration	286,433	17,929	536,776	841,138		841,138	(5,991)	835,147		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,047,725	443,921	1,414,802	3,906,448		3,906,448	(33,270)	3,873,178		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.

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			109,123	109,123		109,123	34,598	143,721			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,083	6,083		6,083	(6,083)				32
33	Real Estate Taxes			55,031	55,031		55,031		55,031			33
34	Rent-Facility & Grounds			57,600	57,600		57,600	(57,600)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			227,837	227,837		227,837	(29,085)	198,752			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			600	600		600		600			38
39	Ancillary Service Centers		128,655	56	128,711		128,711		128,711			39
40	Barber and Beauty Shops	10,684	206		10,890		10,890		10,890			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,335	49,335		49,335		49,335			42
43	Other (specify):* Non-allowable cost			208,624	208,624		208,624	(208,624)				43
44	TOTAL Special Cost Centers	10,684	128,861	258,615	398,160		398,160	(208,624)	189,536			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,058,409	572,782	1,901,254	4,532,445		4,532,445	(270,979)	4,261,466			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				4
5	Telephone, TV & Radio in Resident Rooms	(5,191)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	29,900	30		9
10	Interest and Other Investment Income	(6,083)	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	(131,800)	43		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	(9,338)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(92)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(95,473)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (218,077)		\$	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)	(52,902)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (52,902)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (270,979)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (6,005)	43	1
2	X-Rays - Part A	(3,325)	43	2
3	Disallow office Expense	(272)	43	3
4	Disallow PAC donations	(4,702)	43	4
5	Disallow Donations expense	(1,995)	43	5
6	Disallow apartment costs	(963)	43	6
7	Disallow insurance other	(43,363)	43	7
8	Offset vending machine revenue	(3,878)	43	8
9	Disallow non-allowable legal	(134)	43	9
10	Disallow gain/loss on disposal of asset	(102)	21	10
11	Pop Cost	(1,342)	22	11
12	Offset Uniform Sale	(5,166)	43	12
13	Offset Misc. Sales	(825)	43	13
14	Offset Misc. Expenses	(23,401)		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	(95,473)		49

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Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

STATE OF ILLINOIS

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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.		\$ 4,698	\$ 4,698	1
2	V	34 Rent	57,600	Medina Manor Building, Inc.			(57,600)	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		\$ 57,600			\$ 4,698	\$ * (52,902)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

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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	\$ 151,408	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	\$ 151,408		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

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

Name of Related Organization _____

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			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

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6		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	\$	01/22/2009	0.0399	\$	1								
2	State Bank of Davis		X	Vehicle Loan	\$784.02	10/20/2005	40,070	16,124	10/20/10	0.0650		477								
3												3								
4												4								
5												5								
	Working Capital																			
6	State Bank of Davis		X	Working Capital	None	6/27/08	200,000	84,257	6/27/10	0.0500		5,606								
7	J. Oksnevad	X		Working Capital	None	Varies	Varies	3,095	Demand	None										
8												8								
9	TOTAL Facility Related				\$1,704.62		\$ 295,306	\$ 103,476			\$	6,083								
	B. Non-Facility Related*																			
10												10								
11												11								
12												12								
13									Interest income offset			(6,083)								
14	TOTAL Non-Facility Related						\$	\$			\$	(6,083)								
15	TOTALS (line 9+line14)						\$ 295,306	\$ 103,476			\$									

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.)

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X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Medina Manor Apartments

Retirement Apartments

22 units

20,000 Sq. Ft.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

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		
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
Improvement Type**										
9	Building Improvements		1968	675		15			675	9
10	Building Improvements		1974	861		10			861	10
11	Building Improvements		1975	1,547		10			1,547	11
12	Building Improvements		1976	345		9			345	12
13	Building Improvements		1977	12,614		21			12,614	13
14	Building Improvements		1977	2,793		8			2,793	14
15	Building Improvements		1979	2,620		7			2,620	15
16	Building Improvements		1980	24,465		20			24,465	16
17	Building Improvements		1980	2,137		7			2,137	17
18	Building Improvements		1981	20,211		15			20,211	18
19	Building Improvements		1982	2,305		20			2,305	19
20	Building Improvements		1983	705		5			705	20
21	Building Improvements		1985	980		10			980	21
22	Building Improvements		1985	3,091		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	14,567	14,212	25
26	Building Improvements		1989	30,063		20	753	753	30,063	26
27	Building Improvements		1990	1,601		20	80	80	1,564	27
28	Building Improvements		1991	51,619	1,147	20	2,581	1,434	47,748	28
29	Building Improvements		1991	11,626		20	581	581	10,170	29
30	Building Improvements		1992	39,070	2,605	20	1,954	(651)	32,239	30
31	Building Improvements		1992	3,295	203	20	165	(38)	2,885	31
32	Building Improvements		1992	19,372		20	969	969	16,955	32
33	Building Improvements		1992	23,809	2,362	20	1,190	(1,172)	20,825	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

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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)	\$ 30,577	37
38	Building Improvements	1993	100,000		20	5,000	5,000	81,699	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	41,774	39
40	Building Improvements	1994	15,610		10			15,610	40
41	Building Improvements	1995	47,826	3,188	15	3,188		46,227	41
42	Building Improvements	1995	36,144	2,410	15	2,410		34,944	42
43	Outdoor Signs	1996	2,149	143	15	143		1,931	43
44	Backflow Preventors	1996	3,679	245	15	245		3,308	44
45	Garbage Disposal	1996	761	51	15	51		668	45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		212	46
47	Door	1997	1,996	133	15	133		1,663	47
48	Sign	1997	666	44	15	44		551	48
49	Air Conditioner	1997	3,500	233	15	233		2,913	49
50	Lights	1997	621	41	15	41		513	50
51	Driveway	1997	2,875	192	15	192		2,400	51
52	Fire Alarm	1997	1,246	83	15	83		1,038	52
53	Plumbing	1997	5,122	341	15	341		4,263	53
54	Telephone System	1997	1,152	77	15	77		938	54
55	Permanent Outdoor Receptacles	1997	585	39	15	39		488	55
56	Office Remodeling	1998	2,454	164	15	164		1,886	56
57	Exterior Doors	1998	7,652	510	15	510		5,865	57
58	Windows	1998	15,536	1,036	15	1,036		11,914	58
59	Roof Repair	1998	2,317	154	15	154		1,771	59
60	Water and Sewer Improvements	1998	3,165	211	15	211		2,425	60
61	Fire Alarm	1998	1,157	77	15	77		866	61
62	Telephone System	1998	1,467	98	15	98		1,125	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,341,920	\$ 21,643		\$ 33,087	\$ 25,656	\$ 1,265,188	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:

01/01/2009 Ending: 12/31/2009

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	\$ 21,643		\$ 33,087	\$ 11,444	\$ 1,265,188	1
2	Blinds	1999	3,689	246	15	246		2,581	2
3	Window Replacement	1999	5,145	305	15	343	38	3,602	3
4	Rewire & Replumb Laundry Room	1999	7,824	481	15	522	41	5,475	4
5	Floor Tile	1999	1,049	70	15	70		735	5
6	Air Conditioning	1999	1,895	126	15	126		1,323	6
7	Boiler	1999	535	36	15	36		372	7
8	Sidewalk	2000	1,386	92	15	92		874	8
9	Kickplates	2000	608	41	15	41		384	9
10	Landscaping Brick	2000	1,139	76	15	76		722	10
11	Blacktop Parking Lot	2001	15,000	1,000	15	1,000		8,500	11
12	Dumpster Gate Frames	2001	1,650	110	15	110		935	12
13	Dumpster Concrete Platform	2001	3,700	247	15	247		2,099	13
14	Stone Wall	2001	1,665	111	15	111		943	14
15	Video Surveillance	2002	14,865	991	15	991		7,433	15
16	Wrought Iron Fence	2002	5,105	340	15	340		2,550	16
17	Nurses Call System	2002	12,726	848	15	848		6,360	17
18	Custom Doors	2002	9,427	628	15	628		4,710	18
19	Windows Framing	2003	11,656	777	15	777		5,051	19
20	Roof	2003	7,470	498	15	498		3,237	20
21	Alarm Installation	2003	12,730	849	15	849		5,518	21
22	Cabinets	2004	504	34	15	34		187	22
23	Surveillance Cameras	2004	578	39	15	39		213	23
24	Time Clock	2004	10,000	667	15	667		3,667	24
25	Latches	2004	8,923	595	15	595		3,271	25
26	Exhaust Hood	2004	4,290	286	15	286		1,573	26
27	Bath Call Light	2004	1,229	82	15	82		451	27
28	Ventilator	2004	1,038	69	15	69		381	28
29	Driveway	2004	4,000	267	15	267		1,467	29
30	Sidewalk & Driveway	2005	5,209	347	15	347		1,561	30
31	Wiring & Outlets	2005	8,903	594	15	594		2,672	31
32	Windows	2005	1,911	127	15	127		572	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,507,769	\$ 32,622		\$ 44,145	\$ 11,523	\$ 1,344,607	34

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:

01/01/2009 Ending: 12/31/2009

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	\$ 32,622		\$ 44,145	\$ 11,523	\$ 1,344,607	1
2	Flag Poles	2005	4,362	291	15	291		1,309	2
3									3
4	Fire Alarm System	2006	12,455	415	15	830	415	2,905	4
5	Doors and Gaskets	2006	6,545	218	15	436	218	1,526	5
6	Water Softner	2006	965	32	15	64	32	224	6
7	Landscaping Improvements	2006	2,377	79	15	158	79	553	7
8	Timeclock	2006	20,715	691	15	1,382	691	4,837	8
9	Roofing	2006	1,350	45	15	90	45	315	9
10	Fire Door	2006	965	32	15	64	32	223	10
11	Hot Water Storage Tank	2006	11,998	400	15	800	400	2,800	11
12	A/C Compressor	2006	1,777	59	15	118	59	413	12
13	Fire Alarm Panel	2006	3,200	107	15	214	107	749	13
14									14
15	Roofing	2007	2,675	178	15	178		445	15
16	Fire Safety Doors	2007	3,111	207	15	207		518	16
17	Kitchen Cabinets	2007	4,131	275	15	275		688	17
18	Water Treatment System	2007	11,465	764	15	764		1,910	18
19	Timeclock system	2007	4,034	269	15	269		672	19
20									20
21	Sprinkler	2008	33,686	2,246	15	2,246		3,369	21
22	Tub room improvements	2008	20,275	1,352	15	1,352		2,028	22
23	Generator	2008	44,840	2,990	15	2,990		4,485	23
24	Wiring	2008	12,182	812	15	812		1,218	24
25	Pipe Insulation	2008	6,807	454	15	454		681	25
26	Fire Stops	2008	4,368	292	15	292		438	26
27	Sidewalk replacement	2008	4,805	320	15	320		480	27
28	Dining Room Doors	2008	8,397	560	15	560		840	28
29	Ceiling work	2008	4,374	292	15	292		438	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,739,628	\$ 46,002		\$ 59,603	\$ 13,601	\$ 1,378,671	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,739,628	\$ 46,002		\$ 59,603	\$ 13,601	\$ 1,378,671	1
2	Ceiling Work - North/Center Hall	2009	25,166	629	20	629		315	2
3	A/C West Hall	2009	87,956	2,199	20	2,199		1,100	3
4	Built in Cabinets	2009	4,851	121	20	121		61	4
5	A/C Dining Room	2009	8,500	213	20	213		107	5
6	Fire Alarm	2009	2,607	65	20	65		33	6
7	Sprinkler	2009	5,260	132	20	132		66	7
8	Carpet	2009	4,988	125	20	125		63	8
9									9
10	To Adjust Book Depreciation to FS			14,508			(14,508)		10
11									11
12									12
13	Allocated from home office					4,698	4,698		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,878,956	\$ 63,994		\$ 67,785	\$ 3,791	\$ 1,380,413	34

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:

01/01/2009

Ending:

12/31/2009

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	\$ 427,104	\$ 16,730	\$ 40,978	\$ 24,248	5-10	\$ 293,702	71
72	Current Year Purchases	81,127	8,113	8,113	0	10	8,113	72
73	Fully Depreciated Assets	63,829					63,829	73
74								74
75	TOTALS	\$ 572,060	\$ 24,843	\$ 49,091	\$ 24,248		\$ 365,644	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	\$	\$	\$	5	\$ 9,409	76
77	Resident Van	1991 Chevy Lumina	1991	18,008				5	18,008	77
78	Activity Bus	1998 Ford Bus	1998	49,705				5	49,705	78
79	Schedule 13A			197,843	20,286	26,845	6,559		150,699	79
80	TOTALS			\$ 274,965	\$ 20,286	\$ 26,845	\$ 6,559		\$ 227,821	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)	\$ 2,729,029	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 109,123	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 143,721	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 34,598	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,973,878	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

1/1/2009 to 12/31/2009

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	2,142	1	5	30,000
Maintenance	2004 F250 Ford Pic	2004	51,020	3,644	10,204	(6,560)	5	51,020
Maintenance	2005 Ford Freestar	2005	8,436	1,687	1,687	-	5	7,592
Administrative	2006 Mercedes	2005	64,062	12,812	12,812	-	5	57,654
Administrative	2006 Dodge Van	2009	18,207	3,641	1,821		5	1,821
Administrative	2006 Ford Bus	2009	15,506	3,101	1,551		5	1,551
Maintenance	1999 Dodge Truck	2009	10,612	2,122	1,061		5	1,061
TOTAL			197,843	\$20,286	\$26,845	(\$6,559)		\$150,699

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:		
	<input type="checkbox"/> NO			IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
				IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
				COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER CNA <u>80</u>
		HOURS PER CNA <u>40</u>			

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	TOTAL See Schedule 15A	\$	\$ 49,342	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$	49,342		

C. CONTRACTUAL INCOME

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

\$ 19,375

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	<u>13</u>
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	13

- (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

Medina Nursing Center, Inc.
Provider # 0011551
12/31/2009

Schedule 15A

Schedule XV
Income Statement

Line 13A- CAN

Account Description	Drop Outs	Completed	Contracted	Total
CNA First Office		8,368		8,368
CNA First Office Supply		3,823		3,823
CNA First Computer Fees		1,043		1,043
CNA First Insurance		550		550
CNA First Insurance		1,872		1,872
CNA Teacher Training		850		850
CNA First Travel		1,376		1,376
CNA First		7,993		7,993
CNA First Rent		12,000		12,000
CNA First Telephone		157		157
CNA First General Advertising		10,752		10,752
CNA First Physicals		318		318
CNA First Background Checks		240		240
		49,342		49,342

See Accountants' Compilation

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	\$	2,160	\$ 155,498	\$	2,160	\$ 155,498	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		545	39,206		545	39,206	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)(3)	hrs		2,763	198,957	3,886	2,763	202,843	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				128,655		128,655	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	5,468	\$ 393,661	\$ 132,541	5,468	\$ 526,202	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: **01/01/2009**

Ending:

12/31/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 122,663	\$ 122,663	1
2	Cash-Patient Deposits	18,569	18,569	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>55,000</u>)	531,127	531,127	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,021	8,021	6
7	Other Prepaid Expenses	4,630	4,630	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>N/P - Apartments</u>	76,100	76,100	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 761,110	\$ 761,110	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,048	13
14	Buildings, at Historical Cost		646,817	14
15	Leasehold Improvements, at Historical Cost	1,021,264	1,232,139	15
16	Equipment, at Historical Cost	975,845	847,025	16
17	Accumulated Depreciation (book methods)	(1,190,574)	(1,973,878)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 806,535	\$ 755,151	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,567,645	\$ 1,516,261	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 198,468	\$ 198,468	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,569	18,569	28
29	Short-Term Notes Payable	3,095	3,095	29
30	Accrued Salaries Payable	80,826	80,826	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,500	52,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37	<u>Other Current Liabilities</u>	682	682	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 354,140	\$ 354,140	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	100,381	100,381	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 100,381	\$ 100,381	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 454,521	\$ 454,521	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,113,124	\$ 1,061,740	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,567,645	\$ 1,516,261	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 993,992	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(1,119)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 992,873	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	120,251	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 120,251	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)	\$ 1,113,124	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center# 0011551Report Period Beginning: 01/01/2009Ending: 12/31/2009

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	\$ 4,564,150	1
2	Discounts and Allowances for all Levels	(688,997)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,875,153	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	489,345	6
7	Oxygen	9,065	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 498,410	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	5,975	13
14	Non-Patient Meals	3,878	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	124,105	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,374	19
20	Radiology and X-Ray		20
21	Other Medical Services	100,819	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 242,151	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,976	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,976	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See Schedule 19A</u>	29,006	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 29,006	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,652,696	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	998,753	31
32	Health Care	2,066,557	32
33	General Administration	841,138	33
B. Capital Expense			
34	Ownership	227,837	34
C. Ancillary Expense			
35	Special Cost Centers	348,825	35
36	Provider Participation Fee	49,335	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,532,445	40
41	Income before Income Taxes (line 30 minus line 40)**	120,251	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 120,251	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.
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
12/31/2009

Schedule 19A

Schedule XVII
Income Statement

Line 28A- Other Revenues

	Amount
Pop Sales	1,326.00
Candy Sales	407.00
Office Sales	127.00
Uniform Sales	7,073.00
Miscellaneous Sales	51.00
Anything Else Sales	647.00
	<u>9,631.00</u>
	<u><u>9,631.00</u></u>

See Accountants' Compilation

Facility Name & ID Number **Medina Nursing Center**

0011551

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,960	2,080	\$ 66,508	\$ 31.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,643	7,559	175,618	23.23	3
4	Licensed Practical Nurses	8,557	9,133	194,770	21.33	4
5	CNAs & Orderlies	48,834	50,756	566,169	11.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,796	5,087	54,662	10.75	9
10	Activity Assistants					10
11	Social Service Workers	4,034	4,307	81,777	18.99	11
12	Dietician	1,984	2,080	36,772	17.68	12
13	Food Service Supervisor	3,134	3,384	62,807	18.56	13
14	Head Cook	17,701	18,773	157,817	8.41	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,113	6,368	61,169	9.61	17
18	Housekeepers	9,404	10,006	113,586	11.35	18
19	Laundry	6,934	7,373	71,007	9.63	19
20	Administrator	3,039	3,120	151,408	48.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,774	9,309	135,025	14.50	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	1,930	2,106	22,704	10.78	31
32	Other Health C: See SCH20A	4,218	4,535	95,926	21.15	32
33	Other(specify) <u>Beautician</u>	928	1,047	10,684	10.20	33
34	TOTAL (lines 1 - 33)	138,983	147,023	\$ 2,058,409 *	\$ 14.00	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	\$ 7,955	1(3)	35
36	Medical Director	Monthly	15,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	8,799	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	13	960	11(3)	44
45	Social Service Consultant	7	506	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	161	\$ 33,820		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	31	\$ 1,332	10 (3)	50
51	Licensed Practical Nurses	1,840	66,225	10 (3)	51
52	Certified Nurse Assistants/Aides	6,750	135,008	10 (3)	52
53	TOTAL (lines 50 - 52)	8,621	\$ 202,565		53

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center
Provider #: 0011551
01/01/09 - 12/31/09

Schedule 20A

XVIII. Staffing & Salary Cost	Hours Wrkd	Hours Pd	Total Wages	Avg Hrly Wage
Line 32 - Other Healthcare				
Restorative Nurse	2,089	2,248	48,974	21.79
Care Plan Coordinator	2,129	2,287	46,952	20.53
	<u>4,218</u>	<u>4,535</u>	<u>95,926</u>	<u>21.15</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 151,408	Workers' Compensation Insurance	\$ 69,279	IDPH License Fee	\$ 1,362	
				Unemployment Compensation Insurance	11,797	Advertising: Employee Recruitment	2,817	
				FICA Taxes	150,291	Health Care Worker Background Check		
				Employee Health Insurance	115,838	(Indicate # of checks performed <u>69</u>)	1,106	
				Employee Meals		Patient Background Checks	0	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous License & Fees	1,461	
				Employee Retirement	37,362	IHCA Dues	4,767	
				Employee Relations	11,970	Miscellaneous Dues & Subscriptions		
				Employee Physicals	2,502			
				Pre-Screens	1,024			
						Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 151,408	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 400,063		\$ 11,513		
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	\$			N/A		\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	11,917
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type	Amount		\$			()	
See Sch 21A		\$ 76,485					TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 11,917	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 76,485					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Medina Nursing Center
 Provider #: 0011551
 01/01/08 - 12/31/08

Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount	Legal	
			Invoice #	Amount
Reno & Zahm, LLP	Legal	30 A		
Dueane Morris	Legal	13,159 A	1477351	1,998
McGladrey & Pullen	Accounting	29,849	1486142	2,227
Mediacom	Computer Services	1,099	1494880	367
Business Mgmt. Services	Computer Services	12,737	1516582	843
Wisconsin Physicians Services	Computer Services	23	1501880	104
eHealth	Computer Services	2,700	1533466	413
Dresser Associates	Computer Services	2,200	1526037	7,207
Chase	Computer Services	1,103	36726	30
Ivans	Computer Services	279		13,189 A
Unitime Systems	Computer Services	2,137		
MDI	Computer Services	10,770		
Holgeir	Computer Services	399		
		<u>76,485</u>		

TOTAL (agree to Schedule V, line 19, column 3) 76,485.00

Less: Disallowed legal 0.00

TOTAL (agree to Schedule V, line 19, column 8) 76,485.00

See Accountants' Compilation

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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 - 4767.16
- (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. \$ 4,659 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. \$ 49,335
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,878
- (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
- (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.

SEE ACCOUNTANTS' COMPILATION REPORT