

Facility Name & ID Number Medina Nursing Center

0011551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	13,777	9,767	2,377	25,921	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,777	9,767	2,377	25,921	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.79%

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 2,377

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	263,848	21,147	8,558	293,553		293,553		293,553		1
2	Food Purchase		221,263		221,263		221,263	(2,917)	218,346		2
3	Housekeeping	119,925	35,043		154,968		154,968		154,968		3
4	Laundry	69,441	14,028		83,469		83,469		83,469		4
5	Heat and Other Utilities			104,798	104,798		104,798		104,798		5
6	Maintenance	41,018	29,503	73,124	143,645		143,645		143,645		6
7	Other (specify):*										7
8	TOTAL General Services	494,232	320,984	186,480	1,001,696		1,001,696	(2,917)	998,779		8
	B. Health Care and Programs										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	1,222,607	97,637	111,584	1,431,828		1,431,828		1,431,828		10
10a	Therapy		3,011	490,366	493,377		493,377		493,377		10a
11	Activities	58,318	2,615	13,046	73,979		73,979		73,979		11
12	Social Services	36,357		1,012	37,369		37,369		37,369		12
13	CNA Training	30,629	1,174	85,872	117,675		117,675		117,675		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,347,911	104,437	717,480	2,169,828		2,169,828		2,169,828		16
	C. General Administration										
17	Administrative	142,807			142,807		142,807		142,807		17
18	Directors Fees										18
19	Professional Services			112,553	112,553		112,553	(2,250)	110,303		19
20	Dues, Fees, Subscriptions & Promotions			9,581	9,581		9,581		9,581		20
21	Clerical & General Office Expenses	108,739	30,152	11,249	150,140		150,140		150,140		21
22	Employee Benefits & Payroll Taxes			382,220	382,220		382,220	(999)	381,221		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,941	8,941		8,941		8,941		24
25	Other Admin. Staff Transportation			8,619	8,619		8,619		8,619		25
26	Insurance-Prop.Liab.Malpractice			24,125	24,125		24,125		24,125		26
27	Other (specify):*										27
28	TOTAL General Administration	251,546	30,152	557,288	838,986		838,986	(3,249)	835,737		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,093,689	455,573	1,461,248	4,010,510		4,010,510	(6,166)	4,004,344		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:

01/01/10

Ending:

12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			109,876	109,876		109,876	30,685	140,561			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,998	16,998		16,998	(15,975)	1,023			32
33	Real Estate Taxes			54,421	54,421		54,421		54,421			33
34	Rent-Facility & Grounds			46,800	46,800		46,800	(46,800)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			228,095	228,095		228,095	(32,090)	196,005			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,000	3,000		3,000		3,000			38
39	Ancillary Service Centers		147,265		147,265		147,265		147,265			39
40	Barber and Beauty Shops	11,308	402		11,710		11,710		11,710			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,728	48,728		48,728		48,728			42
43	Other (specify):* Non-Allowable Cos	51,119	5,385	243,684	300,188		300,188	(300,188)				43
44	TOTAL Special Cost Centers	62,427	153,052	295,412	510,891		510,891	(300,188)	210,703			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,156,116	608,625	1,984,755	4,749,496		4,749,496	(338,444)	4,411,052			45

*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

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	(2,917)	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	25,617	30		9
10	Interest and Other Investment Income	(15,975)	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	(14,821)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,500)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(280,116)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (296,712)		\$	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)	(41,732)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (41,732)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (338,444)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center

ID# 0011551

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs	\$ (7,043)	43	1
2	X-Rays	(2,137)	43	2
3	Personal Supplies	(5,135)	43	3
4	Legal	(2,250)	19	4
5	Non-Covered Meds	(250)	43	5
6	Legal Collections	(145)	43	6
7	PAC Donations	(10,024)	43	7
8	Standing	(170,324)	43	8
9	Uniform Revenue	(999)	43	9
10	Other Insurance Costs	(24,056)	43	10
11	Apartment	(45)	43	11
12	Internet Costs	(8,001)	43	12
13	Gain/Loss on disposal of FA	6,000	43	13
14	Goodwill	(4,588)	43	14
15	Admissions & Marketing Salaries	(51,119)	43	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	(280,116)		49

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	46,800	Medina Manor Building, Inc.			(46,800)	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		\$ 46,800			\$ 5,068	\$ * (41,732)	14

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	\$ 142,807	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	\$ 142,807		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:

01/01/10

Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7			N/A						7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Medina Nursing Center

0011551

Report Period Beginning:

01/01/10

Ending:

12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										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	Durand Bank		X	Vehicle Loan	\$372.94	05/29/09	\$ 12,150	\$ 6,024	05/29/12	0.0650	\$ 821	1							
2												2							
3												3							
4												4							
5												5							
Working Capital																			
6	State Bank of Davis		X	Working Capital	None	06/27/08	200,000	177,052	06/27/11	0.0500	6,780	6							
7	Durand Bank			Working Capital	None	08/14/10	350,000	158,571	08/14/11	0.0500	7,358	7							
8	H. Oksnevad	X		Working Capital	None	Varies	Varies	167,110	Demand	None		8							
9	TOTAL Facility Related				\$372.94		\$ 562,150	\$ 508,757			\$ 14,959	9							
B. Non-Facility Related*																			
10							Bank Charges				1,023	10							
11												11							
12												12							
13								Interest Income Offset			(15,982)	13							
14	TOTAL Non-Facility Related						\$	\$			\$ (14,959)	14							
15	TOTALS (line 9+line14)						\$ 562,150	\$ 508,757			\$	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 2009 report.		\$	52,500	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.)	2009	\$	51,921	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(579)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	55,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	54,421	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	42,836	8	
	2006	44,917	9	
	2007	45,996	10	
	2008	50,530	11	
	2009	51,920	12	

2010 RE Taxes \$51,920				
Est Incr for 2011 4.817%				
Computed Total \$54,420.99				
Will use \$55,000				

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	\$		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.

SEE ACCOUNTANTS' COMPILATION REPORT

2009 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 2009 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 2009.

	(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>1,082.20</u>	\$ <u>1,082.20</u>
2.	<u>05-15-251-002</u>	<u>Medina Manor Building</u>	\$ <u>49,732.36</u>	\$ <u>49,732.36</u>
3.	<u>05-15-251-003</u>	<u>Medina Manor Building</u>	\$ <u>1,105.98</u>	\$ <u>1,105.98</u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS			\$ <u><u>51,920.54</u></u>	\$ <u><u>51,920.54</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning:

01/01/10

Ending:

12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,000 B. General Construction Type: Exterior Brick Frame Masonry, Fire Resist 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	5,124	5,124	158,173	5
6										6
7		Allocated from Real Estate entity					5,068	5,068		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			14,212	25
26	Building Improvements		1989	30,063		20			30,063	26
27	Building Improvements		1990	1,601		20	37	37	1,601	27
28	Building Improvements		1991	51,619	1,147	20	2,581	1,434	50,329	28
29	Building Improvements		1991	11,626		20	581	581	10,751	29
30	Building Improvements		1992	39,070	2,605	20	1,954	(651)	34,193	30
31	Building Improvements		1992	3,295	203	20	165	(38)	3,050	31
32	Building Improvements		1992	19,372		20	969	969	17,924	32
33	Building Improvements		1992	23,809	2,362	20	1,190	(1,172)	22,015	33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total
SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning:

01/01/10

Ending:

12/31/10

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)	\$ 32,430	37
38	Building Improvements	1993	100,000		20	5,000	5,000	86,699	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	44,469	39
40	Building Improvements	1994	15,610		10			15,610	40
41	Building Improvements	1995	47,826	3,188	15	3,188		49,415	41
42	Building Improvements	1995	36,144	2,410	15	1,200	(1,210)	36,144	42
43	Outdoor Signs	1996	2,149	143	15	143		2,074	43
44	Backflow Preventors	1996	3,679	245	15	245		3,553	44
45	Garbage Disposal (disposed in 2010)	1996							45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		381	46
47	Door	1997	1,996	133	15	133		1,796	47
48	Sign	1997	666	44	15	44		595	48
49	Air Conditioner	1997	3,500	233	15	233		3,146	49
50	Lights	1997	621	41	15	41		554	50
51	Driveway	1997	2,875	192	15	192		2,592	51
52	Fire Alarm	1997	1,246	83	15	83		1,121	52
53	Plumbing	1997	5,122	341	15	341		4,604	53
54	Telephone System	1997	1,152	77	15	77		1,015	54
55	Permanent Outdoor Receptacles	1997	585	39	15	39		527	55
56	Office Remodeling	1998	2,454	164	15	164		2,050	56
57	Exterior Doors	1998	7,652	510	15	510		6,375	57
58	Windows	1998	15,536	1,036	15	1,036		12,950	58
59	Roof Repair	1998	2,317	154	15	154		1,925	59
60	Water and Sewer Improvements	1998	3,165	211	15	211		2,636	60
61	Fire Alarm	1998	1,157	77	15	77		943	61
62	Telephone System	1998	1,467	98	15	98		1,223	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,341,159	\$ 21,592		\$ 35,595	\$ 14,003	\$ 1,295,047	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:

01/01/10

Ending:

12/31/10

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		\$ 1,341,159	\$ 21,592		\$ 35,595	\$ 14,003	\$ 1,295,047	1
2	Blinds	1999	3,689	246	15	246		2,827	2
3	Window Replacement	1999	5,145	305	15	343	38	3,945	3
4	Rewire & Replumb Laundry Room	1999	7,824	481	15	522	41	5,997	4
5	Floor Tile	1999	1,049	70	15	70		805	5
6	Air Conditioning	1999	1,895	126	15	126		1,449	6
7	Boiler	1999	535	36	15	36		408	7
8	Sidewalk	2000	1,386	92	15	92		966	8
9	Kickplates	2000	608	41	15	41		425	9
10	Landscaping Brick	2000	1,139	76	15	76		798	10
11	Blacktop Parking Lot	2001	15,000	1,000	15	1,000		9,500	11
12	Dumpster Gate Frames	2001	1,650	110	15	110		1,045	12
13	Dumpster Concrete Platform	2001	3,700	247	15	247		2,346	13
14	Stone Wall	2001	1,665	111	15	111		1,054	14
15	Video Surveillance	2002	14,865	991	15	991		8,424	15
16	Wrought Iron Fence	2002	5,105	340	15	340		2,890	16
17	Nurses Call System	2002	12,726	848	15	848		7,208	17
18	Custom Doors	2002	9,427	628	15	628		5,338	18
19	Windows Framing	2003	11,656	777	15	777		5,828	19
20	Roof	2003	7,470	498	15	498		3,735	20
21	Alarm Installation	2003	12,730	849	15	849		6,367	21
22	Cabinets	2004	504	34	15	34		221	22
23	Surveillance Cameras	2004	578	39	15	39		252	23
24	Time Clock	2004	10,000	667	15	667		4,334	24
25	Latches	2004	8,923	595	15	595		3,866	25
26	Exhaust Hood	2004	4,290	286	15	286		1,859	26
27	Bath Call Light	2004	1,229	82	15	82		533	27
28	Ventilator	2004	1,038	69	15	69		450	28
29	Driveway	2004	4,000	267	15	267		1,734	29
30	Sidewalk & Driveway	2005	5,209	347	15	347		1,908	30
31	Wiring & Outlets	2005	8,903	594	15	594		3,266	31
32	Windows	2005	1,911	127	15	127		699	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,507,008	\$ 32,571		\$ 46,653	\$ 14,082	\$ 1,385,524	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:

01/01/10

Ending:

12/31/10

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		\$ 1,507,008	\$ 32,571		\$ 46,653	\$ 14,082	\$ 1,385,524	1
2	Flag Poles	2005	4,362	291	15	291		1,600	2
3									3
4	Fire Alarm System	2006	12,455	415	15	830	415	3,735	4
5	Doors and Gaskets	2006	6,545	218	15	436	218	1,962	5
6	Water Softner	2006	965	32	15	64	32	288	6
7	Landscaping Improvements	2006	2,377	79	15	158	79	711	7
8	Timeclock	2006	20,715	691	15	1,382	691	6,219	8
9	Roofing	2006	1,350	45	15	90	45	405	9
10	Fire Door	2006	965	32	15	64	32	287	10
11	Hot Water Storage Tank	2006	11,998	400	15	800	400	3,600	11
12	A/C Compressor	2006	1,777	59	15	118	59	531	12
13	Fire Alarm Panel	2006	3,200	107	15	214	107	963	13
14									14
15	Roofing	2007	2,675	178	15	178		623	15
16	Fire Safety Doors	2007	3,111	207	15	207		725	16
17	Kitchen Cabinets	2007	4,131	275	15	275		963	17
18	Water Treatment System	2007	11,465	764	15	764		2,674	18
19	Timeclock system	2007	4,034	269	15	269		941	19
20									20
21	Sprinkler	2008	33,686	2,246	15	2,246		5,615	21
22	Tub room improvements	2008	20,275	1,352	15	1,352		3,380	22
23	Generator	2008	44,840	2,990	15	2,990		7,475	23
24	Wiring	2008	12,182	812	15	812		2,030	24
25	Pipe Insulation	2008	6,807	454	15	454		1,135	25
26	Fire Stops	2008	4,368	292	15	292		730	26
27	Sidewalk replacement	2008	4,805	320	15	320		800	27
28	Dining Room Doors	2008	8,397	560	15	560		1,400	28
29	Ceiling work	2008	4,374	292	15	292		730	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,738,867	\$ 45,951		\$ 62,111	\$ 16,160	\$ 1,435,046	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,738,867	\$ 45,951		\$ 62,111	\$ 16,160	\$ 1,435,046	1
2	Ceiling Work - North/Center Hall	2009	25,166	1,678	15	1,888	210	2,517	2
3	A/C West Hall	2009	87,956	5,864	15	6,597	733	8,796	3
4	Built in Cabinets	2009	4,851	323	15	364	41	485	4
5	A/C Dining Room	2009	8,500	567	15	637	70	850	5
6	Fire Alarm	2009	2,607	174	15	196	22	261	6
7	Sprinkler	2009	5,260	351	15	394	43	526	7
8	Carpet	2009	4,988	998	5	1,372	374	1,497	8
9									9
10	A/C Project - Center Hall	2010	79,527	2,651	15	2,651		2,651	10
11	A/C Project - North Hall	2010	51,265	1,709	15	1,709		1,709	11
12	Sprinkler System	2010	42,195	1,407	15	1,407		1,407	12
13	Updating - Center Hall	2010	55,277	1,843	15	1,843		1,843	13
14	A/C Project - Downstairs	2010	66,718	2,224	15	2,224		2,224	14
15	South Hall A/C	2010	31,149	1,038	15	1,038		1,038	15
16	Final - Sprinkler System	2010	7,060	235	15	235		235	16
17	Updating - Center Hall	2010	38,562	1,285	15	1,285		1,285	17
18	Updating - Downstairs	2010	21,568	719	15	719		719	18
19	Updating - North Hall	2010	15,151	505	15	505		505	19
20	Updating - South Hall	2010	26,058	869	15	869		869	20
21	Transfer from CIP	2010	84,287	2,810	15	2,810		2,810	21
22									22
23	To Adjust Book Depreciation to FS			(13,023)			13,023		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)		\$ 2,397,012	\$ 60,178		\$ 90,854	\$ 30,676	\$ 1,467,273	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:

01/01/10

Ending:

12/31/10

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	\$ 478,680	\$ 25,868	\$ 25,861	\$ (7)	5-10	\$ 283,747	71
72	Current Year Purchases	45,856	2,839	2,853	14	5-10	2,846	72
73	Fully Depreciated Assets	197,231					197,231	73
74								74
75	TOTALS	\$ 721,767	\$ 28,707	\$ 28,714	\$ 7		\$ 483,824	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	Residnt Van	1991 Chevy Lumina	1991	18,008					18,008	77
78	from Schedule 13A	Various	Various	143,891	20,991	20,993	2		99,622	78
79										79
80	TOTALS			\$ 171,308	\$ 20,991	\$ 20,993	\$ 2		\$ 127,039	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)	\$ 3,293,135	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 109,876	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 140,561	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 30,685	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,078,136	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, Inc.

Provider #: 0011551

1/1/2010 to

12/31/2010

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
Maintenance	2005 Ford Freestar	2005	8,436	844	844	-	5	8,365
Administrative	2006 Mercedes	2005	64,062	6,406	6,408	(2)	5	62,233
Maintenance	Forklift	2007	6,000	1,200	1,200	-	5	4,200
Maintenance	Kubota RTV	2007	15,700	3,140	3,140	-	5	10,990
Administrative	2006 Dodge Van	2009	18,207	3,641	3,641	-	5	5,462
Administrative	2006 Ford Bus	2009	15,506	3,101	3,101	-	5	4,652
Maintenance	1999 Dodge Truck	2009	10,612	2,122	2,122	-	5	3,183
Maintenance	Trailer	2010	5,368	537	537	-	5	537
TOTAL			143,891	\$20,991	\$20,993	-\$2		\$99,622

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 0 Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2011 \$ _____

13. /2012 \$ _____

14. /2013 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></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)		30,629		30,629
6	Transportation				
7	Contractual Payments				
8	Other Non-Salary Expenses		87,046		87,046
9	TOTALS	\$	\$ 117,675	\$	\$ 117,675
10	SUM OF line 9, col. 1 and 2 (e)	\$	117,675		

C. CONTRACTUAL INCOME

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

\$ 72,842

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	65
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	65

- (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
FYE: 12/31/10

Schedule 15A

Schedule XV
Income Statement

Line 13A- CNA's

Account Description	Drop Outs	Completed	Contracted	Total
Training Coordinator		30,629		30,629
CNA First Office Supply		1,174		1,174
RN Instructor		41,738		41,738
CPR Instructor		1,647		1,647
CNA First Rent		36,000		36,000
CNA First General Advertising		4,799		4,799
CNA First Physicals		601		601
CNA First Background Checks		1,087		1,087
		117,675		117,675

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	10(A)3	hrs	\$	2,327	\$ 167,555	\$	2,327	\$ 167,555	1
2	Licensed Speech and Language Development Therapist	10(A)3	hrs		988	71,109		988	71,109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10(A)3	hrs		3,496	251,702	3,011	3,496	254,713	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				146,984		146,984	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>Dental</u>	39(2)					281		281	13
14	TOTAL			\$	6,811	\$ 490,366	\$ 150,276	6,811	\$ 640,642	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: 01/01/10

Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (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	\$ 12,000	\$ 12,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>55,000</u>)	785,283	785,283	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,652	38,652	6
7	Other Prepaid Expenses	4,630	4,630	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See PG 17A</u>	74,532	74,532	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 915,097	\$ 915,097	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	1,540,080	1,750,195	15
16	Equipment, at Historical Cost	893,078	893,075	16
17	Accumulated Depreciation (book methods)	(1,250,746)	(2,078,136)	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)	\$ 1,182,412	\$ 1,214,999	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,097,509	\$ 2,130,096	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 310,927	\$ 310,927	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	185	185	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	6,083	6,083	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,143	23,143	31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,000	55,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 395,338	\$ 395,338	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	508,757	508,757	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)	\$ 508,757	\$ 508,757	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 904,095	\$ 904,095	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,193,414	\$ 1,226,001	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,097,509	\$ 2,130,096	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Medina Nursing Center
Provider # 0011551
FYE: 12/31/10

PG 17A

Summary of Other Assets (Line #17):

<u>Acct. #</u>	<u>Account Name</u>	<u>Operating</u>	<u>After Consolidation</u>
12390-00-0000	Employee Advances	2,309	2,309
18005-10-0000	Note due from apartments	72,223	72,223
	Total Other Assets	<u>74,532</u>	<u>74,532</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,113,124	1
2	Restatements (describe):		2
3			3
4	Prior Year Adjustment	9,258	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,122,382	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	71,032	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)	\$ 71,032	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)	\$ 1,193,414	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center# 0011551Report Period Beginning: 01/01/10Ending: 12/31/10

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	\$ 2,743,682	1
2	Discounts and Allowances for all Levels	(1,396,336)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,347,346	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,279,031	6
7	Oxygen	3,736	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,282,767	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		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,648,811	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,156	19
20	Radiology and X-Ray	1,825	20
21	Other Medical Services	342,325	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,003,117	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	84,214	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 84,214	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>See Schedule 19A</u>	103,084	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 103,084	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,820,528	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,001,696	31
32	Health Care	2,169,828	32
33	General Administration	838,986	33
B. Capital Expense			
34	Ownership	228,095	34
C. Ancillary Expense			
35	Special Cost Centers	462,163	35
36	Provider Participation Fee	48,728	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,749,496	40
41	Income before Income Taxes (line 30 minus line 40)**	71,032	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 71,032	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.

*** 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
Provider # 0011551
FYE: 12/31/10

19A

Summary of Other Revenue:

31013-00-0000	31013 Miscellaneous	15,882
34010-00-0000	34010 Equipment Rental	440
34013-00-0000	34013 Miscellaneous	66
34055-00-0000	34055 Refunds	957
35010-00-0000	35010 Equipment Rental	9,738
38001-00-0000	CNA First (Tuition from CNA first class)	72,842
38003-00-0000	Miscellaneous	2,917
38004-00-0000	Uniform Sales	1,217
38055-00-0000	Refunds	(975)
	Total Other Revenue	<u>103,084</u>

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

0011551

Report Period Beginning:

01/01/10

Ending:

12/31/10

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	2,040	\$ 64,410	\$ 31.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,719	11,535	240,314	20.83	3
4	Licensed Practical Nurses	6,164	6,650	141,154	21.23	4
5	CNAs & Orderlies	55,329	58,359	650,289	11.14	5
6	CNA Trainees	1,094	1,094	30,629	28.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,144	5,443	58,318	10.71	10
11	Social Service Workers	4,078	4,395	87,476	19.90	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,160	38,092	17.64	13
14	Head Cook	3,370	3,548	63,130	17.79	14
15	Cook Helpers/Assistants	16,637	18,076	162,626	9.00	15
16	Dishwashers					16
17	Maintenance Workers	5,193	5,469	41,018	7.50	17
18	Housekeepers	7,897	8,466	119,925	14.17	18
19	Laundry	8,550	9,259	69,441	7.50	19
20	Administrator	3,120	3,240	142,807	44.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,104	9,756	108,739	11.15	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	1,984	2,200	23,610	10.73	31
32	Other Health C: See PG20A	4,312	4,753	102,830	21.63	32
33	Other(specify) <u>Beautician</u>	1,036	1,116	11,308	10.13	33
34	TOTAL (lines 1 - 33)	147,731	157,559	\$ 2,156,116 *	\$ 13.68	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	164	\$ 8,067	1(3)	35
36	Medical Director	Monthly	15,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				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	16	960	11(3)	44
45	Social Service Consultant	16	1,012	12(3)	45
46	Other(specify)				46
47	<u>CPR Instructor</u>	46	1,647	10(3)	47
48					48
49	TOTAL (lines 35 - 48)	242	\$ 27,286		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	289	\$ 11,873	10(3)	50
51	Licensed Practical Nurses	981	34,284	10(3)	51
52	Certified Nurse Assistants/Aides	2,875	65,427	10(3)	52
53	TOTAL (lines 50 - 52)	4,145	\$ 111,584		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	2,264	2,477	53,671	21.67
Care Plan Coordinator	2,048	2,276	49,159	21.60
	<u>4,312</u>	<u>4,753</u>	<u>102,830</u>	<u>21.63</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center, Inc.
Provider #0011551
FYE: 12/31/10

Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount
RSM MCGladrey	Accounting	2,200
McGladrey & Pullen	Accounting	27,948
Glenn Scott	Legal	2,250
Duane Morris	Legal	330
Point Click Care	Computer Services	28,753
Ivans, Inc	Computer Services	398
eHealth Data Solutions	Computer Services	2,700
Dresser & Associates	Computer Services	2,200
Business Mgmt Services	Computer Services	8,718
3-Cubed Inc	Computer Services	32,329
Storm's Consulting	Computer Services	178
Duane Morris	Computer Services	3,289
FR&R H/Care Consulting	Computer Services	1,260
Total		<u>112,553</u> - Ties to Line :
Less: Nonallowable Legal		(2,250)
Adjusted Total		<u>110,303</u> - Ties to Line :

SEE ACCOUNTANTS' COMPILATION REPORT

#19, Col #3

#19, Col #8

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
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: 01/01/10

Ending: 12/31/10

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 - \$4,667
- (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. \$ 600 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 48,728
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (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. \$ 2,917
- (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? No
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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT