



Facility Name & ID Number Medina Nursing Center

# 0011551 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

**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
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF		552	2,676	3,228	8
9	SNF/PED					9
10	ICF	12,895	6,348		19,243	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,895	6,900	2,676	22,471	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.17%

D. How many bed-hold days during this year were paid by the Department? None (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 59 and days of care provided 2,364

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name &amp; ID Number

Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	282,504	24,995	7,789	315,288		315,288	850	316,138		1
2	Food Purchase		219,645		219,645		219,645	(4,451)	215,194		2
3	Housekeeping	103,410	40,880		144,290		144,290		144,290		3
4	Laundry	77,245	16,951		94,196		94,196		94,196		4
5	Heat and Other Utilities			87,497	87,497		87,497		87,497		5
6	Maintenance	62,345	34,520	43,204	140,069		140,069		140,069		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	525,504	336,991	138,490	1,000,985		1,000,985	(3,601)	997,384		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,600	15,600		15,600		15,600		9
10	Nursing and Medical Records	1,272,271	127,456	143,059	1,542,786		1,542,786	(140)	1,542,646		10
10a	Therapy										10a
11	Activities	95,097	1,904	15,773	112,774		112,774		112,774		11
12	Social Services	90,400		1,065	91,465		91,465		91,465		12
13	CNA Training	28,414		40,869	69,283		69,283		69,283		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,486,182	129,360	216,366	1,831,908		1,831,908	(140)	1,831,768		16
	<b>C. General Administration</b>										
17	Administrative	137,800			137,800		137,800		137,800		17
18	Directors Fees										18
19	Professional Services			88,160	88,160		88,160	(1,240)	86,920		19
20	Dues, Fees, Subscriptions & Promotions			8,284	8,284		8,284		8,284		20
21	Clerical & General Office Expenses	93,895	32,862	8,375	135,132		135,132		135,132		21
22	Employee Benefits & Payroll Taxes			437,388	437,388		437,388	(4,449)	432,939		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,439	9,439		9,439	(240)	9,199		24
25	Other Admin. Staff Transportation			10,619	10,619		10,619		10,619		25
26	Insurance-Prop.Liab.Malpractice			53,553	53,553		53,553		53,553		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	231,695	32,862	615,818	880,375		880,375	(5,929)	874,446		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,243,381	499,213	970,674	3,713,268		3,713,268	(9,670)	3,703,598		29

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

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

Facility Name & ID Number Medina Nursing Center

#0011551

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation							227,162	227,162			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			80,618	80,618		80,618	(36,914)	43,704			32
33	Real Estate Taxes			55,513	55,513		55,513		55,513			33
34	Rent-Facility & Grounds			14,100	14,100		14,100	(14,100)				34
35	Rent-Equipment & Vehicles			4,864	4,864		4,864		4,864			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			155,095	155,095		155,095	176,148	331,243			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,366	505,248	625,614		625,614	(11,050)	614,564			39
40	Barber and Beauty Shops		5,921	12,143	18,064		18,064		18,064			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,065	172,065		172,065		172,065			42
43	Other (specify):* <b>Non-Allowable Co</b>			121,809	121,809		121,809	(121,809)				43
44	<b>TOTAL Special Cost Centers</b>		126,287	811,265	937,552		937,552	(132,859)	804,693			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,243,381	625,500	1,937,034	4,805,915		4,805,915	33,619	4,839,534			45

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

Facility Name & ID Number Medina Nursing Center

# 0011551

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,451)	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	222,094	30		9
10	Interest and Other Investment Income	(36,914)	21		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	(29,004)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(109,074)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 42,651		\$	30

<b>BHF USE ONLY</b>					
48		49	50	51	52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(9,032)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (9,032)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 33,619		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Medina Nursing CenterID# 0011551Report Period Beginning: 01/01/2013Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs	\$ (7,298)	43	1
2	X-Rays	(3,691)	43	2
3	Disallow PAC donations	(2,660)	43	3
4	Disallow Dotation Other	(725)	43	4
5	Disallow Standing Costs	(65,145)	43	5
6	Disallow TV Expenses	(6,203)	43	6
7	Goodwill	(6,368)	43	7
8	IDPH Sanctions	(715)	43	8
9	Disallow Non-Allowable Legal Fees	(390)	19	9
10	Disallow Non-Allowable Travel & Seminar	(240)	24	10
11	Nonallowable Personal Items	(140)	10	11
12	Offset Uniform Purchases	(4,449)	22	12
13	Disallow Non-Allowable Dialysis	(11,050)	39	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(109,074)	49

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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

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.	0.00%	\$ 5,068	\$ 5,068	1
2	V	34 Rent	14,100	Medina Manor Building, Inc.	0.00%		(14,100)	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		\$ 14,100			\$ 5,068	\$ * (9,032)	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: 01/01/2013 Ending: 12/31/2013

## 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	\$ 137,800	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	\$ 137,800		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

Facility Name & ID Number Medina Nursing Center

# 0011551 Report Period Beginning: 01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code N/A \_\_\_\_\_  
 Phone Number (\_\_\_\_) \_\_\_\_\_  
 Fax Number (\_\_\_\_) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4				N/A					4
5									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

Facility Name &amp; ID Number

Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Durand Bank		X	Medina Building Loan	\$9,222.00	06/15/11	\$ 1,289,648	\$ 1,215,457	05/15/16	0.0595	\$ 71,866					
2	Kubota		X	Mower	\$577.60	5/13/13	38,624	31,738	5/13/17							
3																
4																
5																
<b>Working Capital</b>																
6	Davis Bank		X	Working Capital	None	6/27/12	200,105	125,623	6/27/13	0.0500	4,180					
7	Durand Bank		X	Working Capital	None	08/14/12	350,000		08/14/13	0.0500	4,413					
8	H. Oksnevad	X		Working Capital	None	Varies	Varies	22,244	Demand	None						
9	<b>TOTAL Facility Related</b>				\$9,799.60		\$ 1,878,377	\$ 1,395,062			\$ 80,459					
<b>B. Non-Facility Related*</b>																
10																
11																
12											160					
13											(36,914)					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			(36,755)					
15	<b>TOTALS (line 9+line14)</b>						\$ 1,878,377	\$ 1,395,062			\$ 43,704					

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.)\*\* 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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2012 report.			\$	<b>57,260</b>	1														
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2012		\$	<b>55,513</b>	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,747)	3														
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>57,260</b>	4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>55,513</b>	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2008	<u>50,530</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2009	<u>51,920</u>	9																
	2010	<u>53,220</u>	10																
	2011	<u>54,531</u>	11																
	2012	<u>55,513</u>	12																
<b>2012 RE Taxes \$55,513</b>																			
<b>Est Incr for 2013 5%</b>																			
<b>Computed Total \$58,289</b>																			
<b>Will Use \$57,260</b>																			

**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.**

## 2012 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 2012 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 2012.

(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>05-15-251-003</u>	<u>Medina Manor Building</u>	\$ <u>1,182.60</u>	\$ <u>1,182.60</u>
2. <u>05-15-251-008</u>	<u>Medina Manor Building</u>	\$ <u>1,157.06</u>	\$ <u>1,157.06</u>
3. <u>05-15-251-009</u>	<u>Medina Manor Building</u>	\$ <u>53,173.16</u>	\$ <u>53,173.16</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>55,512.82</u></u>	\$ <u><u>55,512.82</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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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:

01/01/2013 Ending:

12/31/2013

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

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

Medina Manor Apartments

Retirement Apartments

22 units

20,000 Sq. Ft.

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

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

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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
5	25	1980	1980	158,173		30			158,173
6									
7				Allocated from Medina Manor Buildig Fund			5,068	5,068	
8									
	<b>Improvement Type**</b>								
9	Building Improvements	1968		675		15			675
10	Building Improvements	1974		861		10			861
11	Building Improvements	1975		1,547		10			1,547
12	Building Improvements	1976		345		9			345
13	Building Improvements	1977		12,614		21			12,614
14	Building Improvements	1977		2,793		8			2,793
15	Building Improvements	1979		2,620		7			2,620
16	Building Improvements	1980		24,465		20			24,465
17	Building Improvements	1980		2,137		7			2,137
18	Building Improvements	1981		20,211		15			20,211
19	Building Improvements	1982		2,305		20			2,305
20	Building Improvements	1983		705		5			705
21	Building Improvements	1985		980		10			980
22	Building Improvements	1985		3,091		20			3,091
23	Building Improvements	1986		17,543		10			17,543
24	Building Improvements	1987		56,373		20			56,373
25	Building Improvements	1988		14,212		20			14,212
26	Building Improvements	1989		30,063		20			30,063
27	Building Improvements	1990		1,601		20			1,601
28	Building Improvements	1991		51,619		20			51,619
29	Building Improvements	1991		11,626		20			11,626
30	Building Improvements	1992		39,070	2,605	20	969	(1,636)	39,070
31	Building Improvements	1992		3,295		20			3,295
32	Building Improvements	1992		19,372		20			19,372
33	Building Improvements	1992		23,809		20			23,809
34									
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	\$ 37,058	\$ 2,471	20	\$ 922	\$ (1,549)	\$ 37,058	37
38	Building Improvements	1993	100,000		20	3,301	3,301	100,000	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	52,554	39
40	Building Improvements	1994	15,610		10			15,610	40
41	Building Improvements	1995	47,826		15			47,826	41
42	Building Improvements	1995	36,144		15			36,144	42
43	Outdoor Signs	1996	2,149		15			2,149	43
44	Backflow Preventors	1996	3,679		15			3,679	44
45	Garbage Disposal (disposed in 2010)	1996							45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		888	46
47	Door	1997	1,996		15			1,996	47
48	Sign	1997	666		15			666	48
49	Air Conditioner	1997	3,500		15			3,500	49
50	Lights	1997	621		15			621	50
51	Driveway	1997	2,875		15			2,875	51
52	Fire Alarm	1997	1,246		15			1,246	52
53	Plumbing	1997	5,122		15			5,122	53
54	Telephone System	1997	1,152		15			1,152	54
55	Permanent Outdoor Receptacles	1997	585		15			585	55
56	Office Remodeling	1998	2,454	76	15	76		2,454	56
57	Exterior Doors	1998	7,652	257	15	257		7,652	57
58	Windows	1998	15,536	514	15	514		15,536	58
59	Roof Repair	1998	2,317	84	15	84		2,317	59
60	Water and Sewer Improvements	1998	3,165	107	15	107		3,165	60
61	Fire Alarm	1998	1,157	60	15	60		1,157	61
62	Telephone System	1998	1,467	48	15	48		1,467	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,341,158	\$ 9,607		\$ 14,270	\$ 4,663	\$ 1,338,168	70

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

Facility Name &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,341,158	\$ 9,607		\$ 14,270	\$ 4,663	\$ 1,338,168	1
2	Blinds	1999	3,689	246	15	246		3,565	2
3	Window Replacement	1999	5,145	305	15	343	38	4,974	3
4	Rewire & Replumb Laundry Room	1999	7,824	481	15	522	41	7,563	4
5	Floor Tile	1999	1,049	70	15	70		1,015	5
6	Air Conditioning	1999	1,895	126	15	126		1,827	6
7	Boiler	1999	535	36	15	36		516	7
8	Sidewalk	2000	1,386	92	15	92		1,242	8
9	Kickplates	2000	608	41	15	41		548	9
10	Landscaping Brick	2000	1,139	76	15	76		1,026	10
11	Blacktop Parking Lot	2001	15,000	1,000	15	1,000		12,500	11
12	Dumpster Gate Frames	2001	1,650	110	15	110		1,375	12
13	Dumpster Concrete Platform	2001	3,700	247	15	247		3,087	13
14	Stone Wall	2001	1,665	111	15	111		1,387	14
15	Video Surveillance	2002	14,865	991	15	991		11,397	15
16	Wrought Iron Fence	2002	5,105	340	15	340		3,910	16
17	Nurses Call System	2002	12,726	848	15	848		9,752	17
18	Custom Doors	2002	9,427	628	15	628		7,222	18
19	Windows Framing	2003	11,656	777	15	777		8,159	19
20	Roof	2003	7,470	498	15	498		5,229	20
21	Alarm Installation	2003	12,730	849	15	849		8,914	21
22	Cabinets	2004	504	34	15	34		323	22
23	Surveillance Cameras	2004	578	39	15	39		369	23
24	Time Clock	2004	10,000	667	15	667		6,335	24
25	Latches	2004	8,923	595	15	595		5,651	25
26	Exhaust Hood	2004	4,290	286	15	286		2,717	26
27	Bath Call Light	2004	1,229	82	15	82		779	27
28	Ventilator	2004	1,038	69	15	69		657	28
29	Driveway	2004	4,000	267	15	267		2,535	29
30	Sidewalk & Driveway	2005	5,209	347	15	347		2,949	30
31	Wiring & Outlets	2005	8,903	594	15	594		5,048	31
32	Windows	2005	1,911	127	15	127		1,080	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,507,007	\$ 20,586		\$ 25,328	\$ 4,742	\$ 1,461,819	34

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

Facility Name &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,507,007	\$ 20,586		\$ 25,328	\$ 4,742	\$ 1,461,819	1
2	Flag Poles	2005	4,362	291	15	291		2,473	2
3									3
4	Fire Alarm System	2006	12,455	415	15	830	415	6,225	4
5	Doors and Gaskets	2006	6,545	218	15	436	218	3,270	5
6	Water Softner	2006	965	32	15	64	32	480	6
7	Landscaping Improvements	2006	2,377	79	15	158	79	1,185	7
8	Timeclock	2006	20,715	691	15	1,382	691	10,365	8
9	Roofing	2006	1,350	45	15	90	45	675	9
10	Fire Door	2006	965	32	15	64	32	479	10
11	Hot Water Storage Tank	2006	11,998	400	15	800	400	6,000	11
12	A/C Compressor	2006	1,777	59	15	118	59	885	12
13	Fire Alarm Panel	2006	3,200	107	15	214	107	1,605	13
14									14
15	Roofing	2007	2,675	178	15	178		1,157	15
16	Fire Safety Doors	2007	3,111	207	15	207		1,346	16
17	Kitchen Cabinets	2007	4,131	275	15	275		1,788	17
18	Water Treatment System	2007	11,465	764	15	764		4,966	18
19	Timeclock system	2007	4,034	269	15	269		1,748	19
20									20
21	Sprinkler	2008	33,686	2,246	15	2,246		12,353	21
22	Tub room improvements	2008	20,275	1,352	15	1,352		7,436	22
23	Generator	2008	44,840	2,990	15	2,990		16,445	23
24	Wiring	2008	12,182	812	15	812		4,466	24
25	Pipe Insulation	2008	6,807	454	15	454		2,497	25
26	Fire Stops	2008	4,368	292	15	292		1,606	26
27	Sidewalk replacement	2008	4,805	320	15	320		1,760	27
28	Dining Room Doors	2008	8,397	560	15	560		3,080	28
29	Ceiling work	2008	4,374	292	15	292		1,606	29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,738,866	\$ 33,966		\$ 40,786	\$ 6,820	\$ 1,557,715	34

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

Facility Name &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 1,738,866	\$ 33,966		\$ 40,786	\$ 6,820	\$ 1,557,715	1
2	Ceiling Work - North/Center Hall	2009	25,166	1,678	15	1,888	210	8,181	2
3	A/C West Hall	2009	87,956	5,864	15	6,597	733	28,587	3
4	Built in Cabinets	2009	4,851	323	15	364	41	1,577	4
5	A/C Dining Room	2009	8,500	567	15	637	70	2,761	5
6	Fire Alarm	2009	2,607	174	15	196	22	849	6
7	Sprinkler	2009	5,260	351	15	394	43	1,708	7
8	Carpet	2009	4,988	998	5	1,372	374	5,613	8
9									9
10	A/C Project - Center Hall	2010	79,527	5,302	15	5,302		18,557	10
11	A/C Project - North Hall	2010	51,265	3,418	15	3,418		11,963	11
12	Sprinkler System	2010	42,195	2,813	15	2,813		9,846	12
13	Updating - Center Hall	2010	55,277	3,685	15	3,685		12,898	13
14	A/C Project - Downstairs	2010	66,718	4,448	15	4,448		15,568	14
15	South Hall A/C	2010	31,149	2,077	15	2,077		7,269	15
16	Final - Sprinkler System	2010	7,060	471	15	471		1,648	16
17	Updating - Center Hall	2010	38,562	2,571	15	2,571		8,998	17
18	Updating - Downstairs	2010	21,568	1,438	15	1,438		5,033	18
19	Updating - North Hall	2010	15,151	1,010	15	1,010		3,535	19
20	Updating - South Hall	2010	26,058	1,737	15	1,737		6,080	20
21	Transfer from CIP	2010	84,287	5,619	15	5,619		19,667	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,397,011	\$ 78,510		\$ 86,823	\$ 8,313	\$ 1,728,053	34

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

Facility Name &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2013 Ending: 12/31/2013

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12D, Carried Forward</b>		\$ 2,397,011	\$ 78,510		\$ 86,823	\$ 8,313	\$ 1,728,053	1
2	Lower level A/C Installation	2011	61,000	4,067	15	4,067		10,167	2
3	South hall A/C work Installation	2011	33,464	2,230	15	2,230		5,575	3
4	Updated-South hall electrical and Plumbing	2011	60,338	3,016	20	3,016		7,540	4
5	Updated-North hall bathroom-flooring,paint and electrical	2011	9,626	482	20	482		1,205	5
6	Updated-Landscaping	2011	13,853	1,386	10	1,386		3,465	6
7	Updated West hall-Bathroom and water softner	2011	4,043	202	20	202		505	7
8	Downstairs bathrooms-Flooring,plumbing	2011	11,187	560	20	560		1,400	8
9	Addition to Sprinkler- south hall	2011	8,135	406	20	406		1,015	9
10	Heating equipment Installation on lower level	2011	21,929	1,096	20	1,096		2,740	10
11	North hall flooring	2011	11,519	576	20	576		1,440	11
12	Updated Outside leasehold courtyard- benches,garden	2011	12,571	1,258	10	1,258		3,145	12
13	Updated and replaced Roof & gutters	2011	80,797	8,080	10	8,080		20,200	13
14	Updated South hall bathroom-Flooring,door,windows	2011	16,442	822	20	822		2,055	14
15	Dialysis project retrofit room	2011	25,000	1,666	15	1,666		4,165	15
16	Ozone unit for washing machines	2011	17,000	1,700	10	1,700		4,250	16
17	Water softener	2011	10,939	546	20	546		1,365	17
18	Water heater system installed including plumbing and piping	2011	41,466	2,764	15	2,764		6,910	18
19									19
20	Labor & Repair to Heating Units	2012	4,875	325	15	325		487	20
21	North & Center Hall:Labor, paint, flooring, wallpaper, etc.	2012	26,712	1,781	15	1,781		2,671	21
22	Dialysis Unit Remodel: Labor, flooring, paint, electrical, etc.	2012	168,368	11,225	15	11,225		16,837	22
23	West Hall: Plumbing, bathroom fixtures, electrical,	2012	49,521	3,301	15	3,301		4,952	23
24	paint, flooring, labor, etc.								24
25									25
26	Dialysis Unit: IDPH & consulting fees, smoke detectors, blinds	2013	25,438	848	15	848		848	26
27	Updated West Hall: ceiling, flooring, electric, paint & labor	2013	45,448	1,515	15	1,515		1,515	27
28	West Hall - Project	2013	20,208	674	15	674		674	28
29	South Shower Rooms Update:Labor,tile,grab bars,plumbing	2013	13,289	443	15	443		443	29
30	slate tile, grout, shower base, faucets, etc.								30
31	Center Hall: Carpet, electrical, paint, pictures, labor, etc.	2013	14,558	485	15	485		485	31
32	West Hall Improvements: ceiling, bathrooms, electric, paint,	2013	8,182	273	15	273		273	32
33	wallpaper, wood, trim, handrails, baseboards, etc.								33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,212,919	\$ 130,237		\$ 138,550	\$ 8,313	\$ 1,834,380	34

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

Facility Name & ID Number Medina Nursing Center

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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 12E, Carried Forward		\$ 3,212,919	\$ 130,237		\$ 138,550	\$ 8,313	\$ 1,834,380	1
2									2
3									3
4	To reconcile to financial statements			(218,848)			218,848		4
5									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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,212,919	\$ (88,611)		\$ 138,550	\$ 227,161	\$ 1,834,380	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 410,537	\$ 41,100	\$ 41,100	\$	15	\$ 257,633	71
72	Current Year Purchases	20,035	1,002	1,002		10	1,002	72
73	Fully Depreciated Assets	350,716					350,716	73
74								74
75	TOTALS	\$ 781,288	\$ 42,102	\$ 42,102	\$		\$ 609,351	75

D. Vehicle Costs. (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	See Schedule 13A	Various	Various	254,125	46,509	46,510	1		136,754	78
79										79
80	TOTALS			\$ 281,542	\$ 46,509	\$ 46,510	\$ 1		\$ 164,171	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)	\$ 4,278,797	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 227,162	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 227,162	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,607,902	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.

Medina Nursing Center, Inc.  
 Provider #0011551  
 FYE: 12/31/13

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	Forklift	2007	6,000	300	300	-	5	6,000
Maintenance	Kubota RTV	2007	15,700	785	785	-	5	15,700
Administrative	2006 Ford Bus	2009	15,506	3,101	3,101	-	5	13,955
Maintenance	Trailer	2010	5,368	1,074	1,074		5	3,758
Administrative	BMW X5	2011	76,085	15,217	15,217		5	38,043
Administrative	Dodge Van	2011	29,688	5,938	5,938		5	14,845
Administrative	Ford Focus	2011	28,877	5,775	5,775		5	14,438
Maintenance	Dodge Truck	2011	39,797	7,959	7,959		5	19,898
Maintenance	Snow Plow & Salt Spreader	2011	5,525	1,105	1,105		5	2,763
Maintenance	Kubota Mower	2012	13,476	2,695	2,695		5	4,043
Maintenance	M&W Industrial - forklift	2012	7,495	1,499	1,499		5	2,249
Maintenance	Trailer	2013	10,608	1,061	1,061		5	1,061
<b>TOTAL</b>			<b>254,125</b>	<b>46,509</b>	<b>46,510</b>	<b>-</b>		<b>136,754</b>

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2014                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

N/A

N/A

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 4,864

Description: Office Equipment \$4,865

(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

\* 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.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/2013 Ending: 12/31/2013  
**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 type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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>80</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>40</u></p>
--	---	--

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		28,414		28,414
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		40,869		40,869
9	TOTALS	\$	\$ 69,283	\$	\$ 69,283
10	SUM OF line 9, col. 1 and 2 (e)	\$	69,283		

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Medina Nursing Center, Inc.

Provider #: 0011551

FYE: 12/31/13

Schedule 15A

<u>CNA FIRST</u>	<u>Account Description</u>	<u>Drop Outs</u>	<u>Completed</u>	<u>Contracted</u>	<u>Total</u>
	Advertising (CNA First program)		4,430		
	Bank Charges		283		
	Background checks		56		
	Rent (Rental of class room & common areas)		36,000		
	Professional (Legal, Consultants)		100		
<b>Total CNA FIRST</b>			<b>40,869</b>		

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39(3)	hrs	\$	2,117	\$ 152,434	\$	2,117	\$ 152,434	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,352	97,352		1,352	97,352	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39(2)(3)	hrs		3,548	255,462	2,027	3,548	257,489	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				118,339		118,339	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			\$	7,017	\$ 505,248	\$ 120,366	7,017	\$ 625,614	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.

Facility Name & ID Number Medina Nursing Center# 0011551Report Period Beginning: 01/01/2013Ending: 12/31/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 11,102	\$ 13,029	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>50,000</u> )	1,012,721	1,012,721	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,181	3,181	6
7	Other Prepaid Expenses	12,130	12,130	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch 17A</u>	20,090	20,090	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,059,224	\$ 1,061,151	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,048	13
14	Buildings, at Historical Cost		646,817	14
15	Leasehold Improvements, at Historical Cost	2,352,613	2,566,102	15
16	Equipment, at Historical Cost	1,068,850	1,062,830	16
17	Accumulated Depreciation (book methods)	(1,505,462)	(2,607,902)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,916,001	\$ 1,670,895	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,975,225	\$ 2,732,046	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 186,750	\$ 186,750	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	797	797	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,278	32,278	31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,260	57,260	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 277,085	\$ 277,085	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,395,062	1,395,062	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,395,062	\$ 1,395,062	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,672,147	\$ 1,672,147	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,303,078	\$ 1,059,899	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,975,225	\$ 2,732,046	48

\*(See instructions.)

Medina Nursing Center, Inc.  
Provider ID# 0011551  
FYE 12/31/13

Schedule 17A

XV. BALANCE SHEET -

<u>Other Current Assets (Specify) :</u>	<u>Operating</u>	<u>After Consolidation</u>
Employee Uniform Purchases	6,605	6,605
Note due from CNA First	13,485	13,485
<b>Total Line 9-Other Current Assets (Specif</b>	<b>20,090</b>	<b>20,090</b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,373,830	1
2	Restatements (describe):		2
3	Prior Year Post Closing Adjustment	(65,465)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,308,365	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(5,287)	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)	\$ (5,287)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,303,078	24 *

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

**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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,159,121	1
2	Discounts and Allowances for all Levels	(2,149,937)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,009,184</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,102,374	6
7	Oxygen	45,764	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,148,138</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	125,774	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	40,733	19
20	Radiology and X-Ray	4,293	20
21	Other Medical Services	297,495	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 468,295</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	36,914	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 36,914</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Schedule 19A	105,133	28
28a	See Schedule 19A	32,964	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 138,097</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,800,628</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,000,985	31
32	Health Care	1,831,908	32
33	General Administration	880,375	33
<b>B. Capital Expense</b>			
34	Ownership	155,095	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	765,487	35
36	Provider Participation Fee	172,065	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 4,805,915</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(5,287)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (5,287)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 118,609	44
45	Private Pay - Net Inpatient Revenue	1,847,131	45
46	Medicare - Net Inpatient Revenue	459,483	46
47	Other-(specify) <u>Hospice</u>	393,746	47
48	Other-(specify) <u>See Schedule 19A</u>	(809,785)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 2,009,184</b>	49

\* 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.

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

Medina Nursing Center, Inc.  
Provider ID# 0011551  
FYE 12/31/13

**Schedule 19A**

**I. Revenue - Support Schedule**

<b>Other Revenue (Specify):</b>	<b>Amount</b>
Equipment Rental	5,076
Equipment Rental	54,920
Equipment Rental	16,348
Equipment Rental	2,028
Equipment Rental	26,437
Equipment Rental	324
Miscellaneous	16,312
Miscellaneous	114
Refunds	52
Miscellaneous	317
Miscellaneous	11,720
Uniform Sales	4,449
<b>Total Other Revenue</b>	<u><u>138,097</u></u>

**I. Net Inpatient Revenue detailed by Payer Source - Support Schedule**

Contractual Allowance - Medicare	(873,561)
Veterans Allowance	63,776
<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<u><u>(809,785)</u></u>

Facility Name & ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,080	\$ 73,100	\$ 35.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,872	13,996	341,638	24.41	3
4	Licensed Practical Nurses	6,828	7,130	160,435	22.50	4
5	CNAs & Orderlies	53,465	56,098	671,015	11.96	5
6	CNA Trainees	1,561	1,758	28,414	16.16	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,151	7,731	95,097	12.30	10
11	Social Service Workers	3,920	4,160	90,400	21.73	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	41,656	20.03	13
14	Head Cook	3,294	3,444	46,984	13.64	14
15	Cook Helpers/Assistants	17,246	18,396	193,864	10.54	15
16	Dishwashers					16
17	Maintenance Workers	4,603	4,843	62,345	12.87	17
18	Housekeepers	7,305	7,986	103,410	12.95	18
19	Laundry	8,187	8,664	77,245	8.92	19
20	Administrator	3,000	3,120	137,800	44.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,949	6,371	93,895	14.74	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	2,152	26,083	12.12	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,325	150,009	\$ 2,243,381 *	\$ 14.95	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	144	\$ 7,124	1(3)	35
36	Medical Director	Monthly	15,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	740	4,514	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	860	11(3)	44
45	Social Service Consultant	16	1,065	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	913	\$ 29,163		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	241	\$ 8,476	10(3)	50
51	Licensed Practical Nurses	2,717	106,705	10(3)	51
52	Certified Nurse Assistants/Aides	1,037	23,364	10(3)	52
53	TOTAL (lines 50 - 52)	3,995	\$ 138,545		53



Medina Nursing Center, Inc.  
Provider ID# 0011551  
FYE 12/31/13

**XIX. Support Schedule**  
**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Ability Network Inc.	Computer Services	840
Various	Computer Services	850
Total (Agree to Schedule V, Line 19, Column 3)		<u>88,160</u>
To reclass computer fees to proper account		(850)
Legal Adjustment		(390)
Total (Agree to Schedule V, Line 19, Column8)		<u>86,920</u>

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Medina Nursing Center

# 0011551

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

## 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 - \$284
- (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? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A 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. \$ 172,065  
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. \$ 2,731 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 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? N/A
- g. Does the facility transport residents to and from day training? Yes**  
**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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.