



Facility Name & ID Number Medina Nursing Center

# 0011551 Report Period Beginning: 1/01/2015 Ending: 12/31/2015

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	0	307	3,144	3,451	8
9	SNF/PED					9
10	ICF	14,201	5,799	0	20,000	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,201	6,106	3,144	23,451	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.19%

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 89 and days of care provided 1,319

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name &amp; ID Number

Medina Nursing Center

# 0011551

Report Period Beginning:

1/01/2015

Ending:

12/31/2015

**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	282,273	20,362	7,819	310,454		310,454		310,454		1
2	Food Purchase		261,736		261,736		261,736		261,736		2
3	Housekeeping	110,442	41,408		151,850		151,850		151,850		3
4	Laundry	46,362	8,600		54,962		54,962		54,962		4
5	Heat and Other Utilities			89,680	89,680		89,680		89,680		5
6	Maintenance	85,091	48,093	47,155	180,339		180,339		180,339		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	524,168	380,199	144,654	1,049,021		1,049,021		1,049,021		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	1,306,437	104,597	127,548	1,538,582		1,538,582		1,538,582		10
10a	Therapy										10a
11	Activities	96,994	1,969	12,355	111,318		111,318		111,318		11
12	Social Services	92,480		1,197	93,677		93,677	(42,560)	51,117		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,495,911	106,566	156,700	1,759,177		1,759,177	(42,560)	1,716,617		16
	<b>C. General Administration</b>										
17	Administrative	137,800			137,800		137,800		137,800		17
18	Directors Fees										18
19	Professional Services			112,766	112,766		112,766	(13,902)	98,864		19
20	Dues, Fees, Subscriptions & Promotions			15,243	15,243		15,243	(2,089)	13,154		20
21	Clerical & General Office Expenses	102,001	13,961	12,418	128,380		128,380		128,380		21
22	Employee Benefits & Payroll Taxes			412,154	412,154		412,154		412,154		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,909	5,909		5,909	(110)	5,799		24
25	Other Admin. Staff Transportation			8,165	8,165		8,165		8,165		25
26	Insurance-Prop.Liab.Malpractice			80,841	80,841		80,841		80,841		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	239,801	13,961	647,496	901,258		901,258	(16,101)	885,157		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,259,880	500,726	948,850	3,709,456		3,709,456	(58,661)	3,650,795		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 &amp; ID Number

Medina Nursing Center

#0011551

Report Period Beginning:

1/01/2015

Ending:

12/31/2015

## 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			208,902	208,902		208,902		208,902			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			87,833	87,833		87,833	(251)	87,582			32
33	Real Estate Taxes			59,412	59,412		59,412	(1,256)	58,156			33
34	Rent-Facility & Grounds			8,100	8,100		8,100	(8,100)				34
35	Rent-Equipment & Vehicles			4,904	4,904		4,904		4,904			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			369,151	369,151		369,151	(9,607)	359,544			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		141,612	320,788	462,400		462,400	(108,334)	354,066			39
40	Barber and Beauty Shops			13,857	13,857		13,857		13,857			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			183,069	183,069		183,069		183,069			42
43	Other (specify):* <b>Non-Allowable Co</b>			30,730	30,730		30,730	(30,730)				43
44	<b>TOTAL Special Cost Centers</b>		141,612	548,444	690,056		690,056	(139,064)	550,992			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,259,880	642,338	1,866,445	4,768,663		4,768,663	(207,332)	4,561,331			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: 1/01/2015

Ending: 12/31/2015

**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		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	(3,350)	30		9
10	Interest and Other Investment Income	(251)	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	(6,368)	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	(192,613)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (202,582)</b>		<b>\$</b>	<b>30</b>

<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)	(4,750)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (4,750)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (207,332)</b>		<b>37</b>

\*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>			<b>\$</b>		<b>47</b>

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs	\$ (6,791)	43	1
2	X-Rays	(5,254)	43	2
3	Disallow PAC donations	(2,232)	43	3
4	Disallow Donations other	(568)	43	4
5	Disallow TV Expenses	(7,833)	43	5
6	Goodwill	(3,954)	43	6
7	Nonallowable Legal	(13,902)	19	7
8	To Disallow nonallowable dialysis	(11,565)	39	8
9	State Income Tax	2,324	43	9
10	Federal Income Tax	(54)	43	10
11	Medications	(1)	39	11
12	Lobby Expense	(2,089)	20	12
13	Admissions	(42,560)	12	13
14	Real Estate	(1,256)	33	14
15	Therapy	(96,767)	39	15
16	Nonallowable Seminar	(110)	24	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>		(192,613)	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
<u>Holgeir J. Oksnevad</u>	<u>100</u>	<u>N/A</u>		<u>Medina Manor Building, Inc.</u>	<u>Durand</u>	<u>Lessor</u>

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	<u>30 Depreciation</u>	\$	<u>Medina Manor Building, Inc.</u>		\$ <u>3,350</u>	\$ <u>3,350</u>	1
2	V	<u>34 Rent</u>	<u>8,100</u>	<u>Medina Manor Building, Inc.</u>			<u>(8,100)</u>	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	<b>Total</b>		\$ <b>8,100</b>			\$ <b>3,350</b>	\$ * <b>(4,750)</b>	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: 1/01/2015 Ending: 12/31/2015

## 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: 1/01/2015

Ending: 2/31/2015

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	N/A								3
4									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:

1/01/2015

Ending:

12/31/2015

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	Name of Lender	2		3	4	5	6		7	8	9	10						
			Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
			YES	NO											Original	Balance			
		<b>A. Directly Facility Related</b>																	
		<b>Long-Term</b>																	
1		Durand Bank		X	Medina Building Loan	\$9,222.00	06/15/11	\$ 1,289,648	\$ 1,132,953	05/15/16	0.0595	\$ 70,954	1						
2		Kubota		X	Mower	\$577.60	5/13/13	38,624	9,627	5/13/17			2						
3		Kubota		X	RTV	\$577.68	4/13/14	22,100	3,436	4/13/18			3						
4													4						
5													5						
		<b>Working Capital</b>																	
6		Davis Bank		X	Working Capital	None	6/27/12	200,105	232,651	11/30/16	0.0500	7,127	6						
7		Durand Bank		X	Working Capital	None	08/14/12	350,000	345,096	11/14/16	0.0500	7,645	7						
8		H. Oksnevad	X		Working Capital	None	Varies	Varies	173,614	Demand	None	2,087	8						
9		<b>TOTAL Facility Related</b>				\$10,377.28		\$ 1,900,477	\$ 1,897,377			\$ 87,813	9						
		<b>B. Non-Facility Related*</b>																	
10													10						
11												20	11						
12												(251)	12						
13													13						
14		<b>TOTAL Non-Facility Related</b>						\$	\$			(231)	14						
15		<b>TOTALS (line 9+line14)</b>						\$ 1,900,477	\$ 1,897,377			\$ 87,582	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.)

\*\* 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 2014 report.			\$	<b>62,000</b>	1										
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2014		\$	<b>59,412</b>	2										
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(2,588)</b>	3										
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>62,000</b>	4										
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5										
		Disallowed Portion Outpatient Therapy Services		<b>(1,256)</b>											
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>58,156</b>	7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<u>53,220</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 2014 \$ _____</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$ _____</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$ _____</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$ _____</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____	14	PLUS APPEAL COST FROM LINE 5 \$ _____	15	LESS REFUND FROM LINE 6 \$ _____	16	AMOUNT TO USE FOR RATE CALCULATION \$ _____
<b>FOR BHF USE ONLY</b>															
13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____														
14	PLUS APPEAL COST FROM LINE 5 \$ _____														
15	LESS REFUND FROM LINE 6 \$ _____														
16	AMOUNT TO USE FOR RATE CALCULATION \$ _____														
	2011	<u>54,531</u>	9												
	2012	<u>55,513</u>	10												
	2013	<u>59,602</u>	11												
	2014	<u>59,412</u>	12												
<b>2015 RE Taxes \$59,412; Est Increase for 2015 5%</b>															
<b>Computed Total \$62,382, Will Use \$62,000</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.**

## 2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Medina Nursing Center, Inc. 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 2014 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 2014.

(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>1,265.50</u>	\$ <u>1,265.50</u>
2. <u>05-15-251-008</u>	<u>Medina Manor Building</u>	\$ <u>1,238.34</u>	\$ <u>1,238.34</u>
3. <u>05-15-251-009</u>	<u>Medina Manor Building</u>	\$ <u>56,907.80</u>	\$ <u>56,907.80</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>59,411.64</u></u>	\$ <u><u>59,411.64</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

**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:

1/01/2015 Ending:

12/31/2015

**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:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident care</u>	<u>304,920</u>	<u>1965</u>	<u>\$ 3,048</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>304,920</b>		<b>\$ 3,048</b>	<b>3</b>

**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 Building Fund			3,350	3,350	
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	52	20	52		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		20			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:

1/01/2015

Ending:

12/31/2015

**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	\$	20	\$	\$	\$ 37,058	37
38	Building Improvements	1993	100,000		20			100,000	38
39	Building Improvements	1994	53,900		20			53,900	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		15			2,532	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		15			2,454	56
57	Exterior Doors	1998	7,652		15			7,652	57
58	Windows	1998	15,536		15			15,536	58
59	Roof Repair	1998	2,317		15			2,317	59
60	Water and Sewer Improvements	1998	3,165		15			3,165	60
61	Fire Alarm	1998	1,157		15			1,157	61
62	Telephone System	1998	1,467		15			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	\$ 52		\$ 3,402	\$ 3,350	\$ 1,341,158	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:

1/01/2015

Ending:

12/31/2015

**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	\$ 52		\$ 3,402	\$ 3,350	\$ 1,341,158	1
2	Blinds	1999	3,689		15			3,689	2
3	Window Replacement	1999	5,145		15			5,145	3
4	Rewire & Replumb Laundry Room	1999	7,824		15			7,824	4
5	Floor Tile	1999	1,049		15			1,049	5
6	Air Conditioning	1999	1,895		15			1,895	6
7	Boiler	1999	535		15			535	7
8	Sidewalk	2000	1,386	46	15	46		1,386	8
9	Kickplates	2000	608	20	15	20		608	9
10	Landscaping Brick	2000	1,139	38	15	38		1,139	10
11	Blacktop Parking Lot	2001	15,000	1,000	15	1,000		14,500	11
12	Dumpster Gate Frames	2001	1,650	110	15	110		1,595	12
13	Dumpster Concrete Platform	2001	3,700	247	15	247		3,577	13
14	Stone Wall	2001	1,665	111	15	111		1,609	14
15	Video Surveillance	2002	14,865	991	15	991		13,379	15
16	Wrought Iron Fence	2002	5,105	340	15	340		4,594	16
17	Nurses Call System	2002	12,726	848	15	848		11,453	17
18	Custom Doors	2002	9,427	628	15	628		8,484	18
19	Windows Framing	2003	11,656	777	15	777		9,714	19
20	Roof	2003	7,470	498	15	498		6,225	20
21	Alarm Installation	2003	12,730	849	15	849		10,608	21
22	Cabinets	2004	504	34	15	34		386	22
23	Surveillance Cameras	2004	578	39	15	39		443	23
24	Time Clock	2004	10,000	667	15	667		7,667	24
25	Latches	2004	8,923	595	15	595		6,841	25
26	Exhaust Hood	2004	4,290	286	15	286		3,289	26
27	Bath Call Light	2004	1,229	82	15	82		942	27
28	Ventilator	2004	1,038	69	15	69		795	28
29	Driveway	2004	4,000	267	15	267		3,066	29
30	Sidewalk & Driveway	2005	5,209	347	15	347		3,646	30
31	Wiring & Outlets	2005	8,903	594	15	594		6,232	31
32	Windows	2005	1,911	127	15	127		1,338	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,507,007	\$ 9,662		\$ 13,012	\$ 3,350	\$ 1,484,811	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

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## 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	Totals from Page 12B, Carried Forward		\$ 1,507,007	\$ 9,662		\$ 13,012	\$ 3,350	\$ 1,484,811	1
2	Flag Poles	2005	4,362	291	15	291		3,053	2
3									3
4	Fire Alarm System	2006	12,455	830	15	830		7,888	4
5	Doors and Gaskets	2006	6,545	436	15	436		4,145	5
6	Water Softner	2006	965	64	15	64		611	6
7	Landscaping Improvements	2006	2,377	158	15	158		1,506	7
8	Timeclock	2006	20,715	1,381	15	1,381		13,120	8
9	Roofing	2006	1,350	90	15	90		855	9
10	Fire Door	2006	965	64	15	64		611	10
11	Hot Water Storage Tank	2006	11,998	800	15	800		7,599	11
12	A/C Compressor	2006	1,777	118	15	118		1,125	12
13	Fire Alarm Panel	2006	3,200	213	15	213		2,027	13
14									14
15	Roofing	2007	2,675	178	15	178		1,516	15
16	Fire Safety Doors	2007	3,111	207	15	207		1,763	16
17	Kitchen Cabinets	2007	4,131	275	15	275		2,341	17
18	Water Treatment System	2007	11,465	764	15	764		6,497	18
19	Timeclock system	2007	4,034	269	15	269		2,286	19
20									20
21	Sprinkler	2008	33,686	2,246	15	2,246		16,843	21
22	Tub room improvements	2008	20,275	1,352	15	1,352		10,138	22
23	Generator	2008	44,840	2,989	15	2,989		22,420	23
24	Wiring	2008	12,182	812	15	812		6,091	24
25	Pipe Insulation	2008	6,807	454	15	454		3,404	25
26	Fire Stops	2008	4,368	291	15	291		2,184	26
27	Sidewalk replacement	2008	4,805	320	15	320		2,402	27
28	Dining Room Doors	2008	8,397	560	15	560		4,199	28
29	Ceiling work	2008	4,374	292	15	292		2,187	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,738,866	\$ 25,116		\$ 28,466	\$ 3,350	\$ 1,611,622	34

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

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	Totals from Page 12C, Carried Forward		\$ 1,738,866	\$ 25,116		\$ 28,466	\$ 3,350	\$ 1,611,622	1
2	Ceiling Work - North/Center Hall	2009	25,166	1,678	15	1,678		10,905	2
3	A/C West Hall	2009	87,956	5,864	15	5,864		38,114	3
4	Built in Cabinets	2009	4,852	323	15	323		2,102	4
5	A/C Dining Room	2009	8,500	567	15	567		3,683	5
6	Fire Alarm	2009	2,607	174	15	174		1,130	6
7	Sprinkler	2009	5,260	351	15	351		2,279	7
8	Carpet	2009	4,988		5			4,988	8
9									9
10	A/C Project - Center Hall	2010	79,527	5,302	15	5,302		29,160	10
11	A/C Project - North Hall	2010	51,265	3,418	15	3,418		18,797	11
12	Sprinkler System	2010	42,195	2,813	15	2,813		15,472	12
13	Updating - Center Hall	2010	55,277	3,685	15	3,685		20,268	13
14	A/C Project - Downstairs	2010	66,718	4,448	15	4,448		24,463	14
15	South Hall A/C	2010	31,149	2,077	15	2,077		11,421	15
16	Final - Sprinkler System	2010	7,060	471	15	471		2,589	16
17	Updating - Center Hall	2010	38,562	2,571	15	2,571		14,139	17
18	Updating - Downstairs	2010	21,568	1,438	15	1,438		7,908	18
19	Updating - North Hall	2010	15,151	1,010	15	1,010		5,555	19
20	Updating - South Hall	2010	26,058	1,737	15	1,737		9,554	20
21	Transfer from CIP	2010	84,287	5,619	15	5,619		30,905	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)		\$ 2,397,012	\$ 68,662		\$ 72,012	\$ 3,350	\$ 1,865,054	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:

1/01/2015

Ending:

12/31/2015

## 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>		\$ 2,397,012	\$ 68,662		\$ 72,012	\$ 3,350	\$ 1,865,054	1
2	Lower level A/C Installation	2011	61,000	4,067	15	4,067		18,300	2
3	South hall A/C work Installation	2011	33,464	2,231	15	2,231		10,039	3
4	Updated-South hall electrical and Plumbing	2011	60,338	4,023	20	4,023		18,101	4
5	Updated-North hall bathroom-flooring,paint and electrical	2011	9,626	642	20	642		2,888	5
6	Updated-Landscaping	2011	13,853	924	10	924		4,156	6
7	Updated West hall-Bathroom and water softner	2011	4,043	270	20	270		1,213	7
8	Downstairs bathrooms-Flooring,plumbing	2011	11,187	746	20	746		3,356	8
9	Addition to Sprinkler- south hall	2011	8,135	542	20	542		2,440	9
10	Heating equipment Installation on lower level	2011	21,929	1,462	20	1,462		6,579	10
11	North hall flooring	2011	11,519	768	20	768		3,456	11
12	Updated Outside leasehold courtyard- benches,garden	2011	12,571	838	10	838		3,771	12
13	Updated and replaced Roof & gutters	2011	80,797	5,386	10	5,386		24,239	13
14	Updated South hall bathroom-Flooring,door,windows	2011	16,442	1,096	20	1,096		4,933	14
15	Dialysis project retrofit room	2011	25,000	1,667	15	1,667		7,500	15
16	Ozone unit for washing machines	2011	17,000	1,133	10	1,133		5,100	16
17	Water softener	2011	10,939	729	20	729		3,282	17
18	Water heater system installed including plumbing and piping	2011	41,466	2,764	15	2,764		12,440	18
19									19
20	Labor & Repair to Heating Units	2012	4,875	325	15	325		1,137	20
21	North & Center Hall:Labor, paint, flooring, wallpaper, etc.	2012	26,712	1,781	15	1,781		6,233	21
22	Dialysis Unit Remodel: Labor, flooring, paint, electrical, etc.	2012	168,368	11,225	15	11,225		39,286	22
23	West Hall: Plumbing, bathroom fixtures, electrical,	2012	49,521	3,301	15	3,301		11,555	23
24	paint, flooring, labor, etc.								24
25									25
26	Dialysis Unit: IDPH & consulting fees, smoke detectors, blinds	2013	25,438	1,272	15	1,272		3,180	26
27	Updated West Hall: ceiling, flooring, electric, paint & labor	2013	45,448	2,272	15	2,272		5,681	27
28	West Hall - Project	2013	20,208	1,010	15	1,010		2,526	28
29	South Shower Rooms Update:Labor,tile,grab bars,plumbing	2013	13,289	664	15	664		1,661	29
30	slate tile, grout, shower base, faucets, etc.								30
31	Center Hall: Carpet, electrical, paint, pictures, labor, etc.	2013	14,558	728	15	728		1,820	31
32	West Hall Improvements: ceiling, bathrooms, electric, paint,	2013	8,182	1,169	15	1,169		2,922	32
33	wallpaper, wood, trim, handrails, baseboards, etc.								33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,212,920	\$ 121,697		\$ 125,047	\$ 3,350	\$ 2,072,848	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:

1/01/2015

Ending:

12/31/2015

**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	<b>Totals from Page 12E, Carried Forward</b>		\$ 3,212,920	\$ 121,697		\$ 125,047	\$ 3,350	\$ 2,072,848	1
2	Updated Center Hall	2014	16,330	1,089	15	1,089		1,633	2
3	- electric, paper, paint, misc								3
4	- flooring								4
5	Updated general heating	2014	31,193	2,080	15	2,080		3,119	5
6	- Equipment (units for heating)								6
7	- Misc (supplies)								7
8	Updated general upstairs	2014	33,945	2,263	15	2,263		3,395	8
9	- electric, paper, paint, misc								9
10	- flooring								10
11	Updated outside of building	2014	9,217	614	15	614		922	11
12	- court yard and entrance								12
13	Roof repair	2014	14,770	1,477	15	1,477		2,216	13
14									14
15	Roof - North Hall	2015	19,636	982	10	982		982	15
16	Updated Lower Level, Resident Dining Room	2015	32,842	1,095	15	1,095		1,095	16
17	- electric, paper, paint, misc								17
18	- flooring								18
19	Updated General upstairs, Main Lounge	2015	7,747	258	15	258		258	19
20	- electric, paper, paint, misc								20
21									21
22									22
23	Disallowed portion due to outpatient therapy					(4,865)	(4,865)		23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	To reconcile to financial statements			6,744		8,259	1,515		33
34	TOTAL (lines 1 thru 33)		\$ 3,378,600	\$ 138,299		\$ 138,299	\$	\$ 2,086,468	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	\$ 672,106	\$ 40,314	\$ 40,314	\$	5-10	\$ 540,426	71
72	Current Year Purchases	35,940	2,659	2,659		5-10	2,659	72
73	Fully Depreciated Assets							73
74	Assets Disposed	(242,173)					(242,173)	74
75	TOTALS	\$ 465,873	\$ 42,973	\$ 42,973	\$		\$ 300,912	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	146,921	27,630	27,630			124,947	78
79										79
80	TOTALS			\$ 174,338	\$ 27,630	\$ 27,630	\$		\$ 152,364	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)	\$ 4,021,858	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 208,902	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 208,902	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,539,744	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.

**Facility Name:** Medina Nursing Center  
**IDPH License ID Number:** 0011551  
**Fiscal Year End:** 12/31/2015

**Schedule 13A**

**XI. Ownership Costs**

**Line 79 - Vehicle Depreciation**

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Administrative	2006 Ford Bus	2009	15,506			-	5	15,506
Maintenance	Trailer	2010	5,368	537	537	-	5	5,368
Administrative	BMW X5	2011	76,085	15,217	15,217	-	5	68,477
Administrative	Dodge Van	2011	29,688	5,938	5,938	-	5	26,719
Administrative	Ford Focus	2011	28,877	5,775	5,775	-	5	25,989
Maintenance	Dodge Truck	2011	39,797	7,959	7,959	-	5	35,817
Maintenance	Snow Plow & Salt Spreader	2011	5,525	1,105	1,105	-	5	4,973
Maintenance	Kubota Mower	2012	13,476	2,695	2,695	-	5	9,433
Maintenance	M&W Industrial - forklift	2012	7,495	1,499	1,499	-	5	5,247
Maintenance	Trailer	2013	10,608	2,122	2,122	-	5	5,305
Asset Disposals			(85,504)	(15,217)	(15,217)			(77,886)
<b>TOTAL</b>			<b>146,921</b>	<b>27,630</b>	<b>27,630</b>	<b>-</b>		<b>124,948</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. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

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: \$ 4,904 Description: See schedule 14A

(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:** Medina Nursing Center  
**IDPH License ID Number:** 0011551  
**Fiscal Year End:** 12/31/2015

**Schedule 14A**

**XIV. Rental Costs**

**Line 16 Rental Amount for Moveable Equipment**

<b>Rental Description</b>	<b>Amount</b>
Office Equipment	4,531
Medical Equipment	373
<b>Total - Line 16</b>	<b><u>4,904</u></b>

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/01/2015 Ending: 12/31/2015  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides.                  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

**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	\$	1,253	\$ 72,917	\$	1,253	\$ 72,917	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		443	30,254		443	30,254	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	39(2)(3)	hrs		2,759	120,849	904	2,759	121,753	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 prescrpts				104,693		104,693	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): <u>See Sch 16A</u>	39(2)					24,449		24,449	12	
13	Other (specify):									13	
14	<b>TOTAL</b>			\$	4,455	\$ 224,020	\$ 130,046	4,455	\$ 354,066	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:** Medina Nursing Center  
**IDPH License ID Number:** 0011551  
**Fiscal Year End:** 12/31/2015

**Schedule 16A**

**XIV. Special Services (Direct Cost)**

**Line 12 Other (specify)**

<b>Description</b>	<b>Units</b>	<b>Amount</b>
Oxygen - Medical - In House		12,639
Doctor Visits - Medical - VA		10,599
Non Covered Meds - Medical - Medicaid/IPAC		1,211
<b>Total - Line 12</b>	<b>-</b>	<b>24,449</b>

Facility Name & ID Number Medina Nursing Center

# 0011551

Report Period Beginning: 1/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(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	\$ 8,389	\$ 10,042	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,000</u> )	1,340,041	1,340,041	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,181	3,181	6
7	Other Prepaid Expenses	4,630	4,630	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Sch 17A</u>	27,140	27,140	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,383,381	\$ 1,385,034	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	2,518,296	2,731,783	15
16	Equipment, at Historical Cost	769,959	640,211	16
17	Accumulated Depreciation (book methods)	(1,787,982)	(2,539,744)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,500,273	\$ 1,482,115	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,883,654	\$ 2,867,149	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 156,235	\$ 156,235	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	44,220	44,220	29
30	Accrued Salaries Payable	681	681	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,077	26,077	31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,000	62,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 289,213	\$ 289,213	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,853,157	1,853,157	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,853,157	\$ 1,853,157	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,142,370	\$ 2,142,370	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 741,284	\$ 724,779	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,883,654	\$ 2,867,149	48

\*(See instructions.)

Facility Name: Medina Nursing Center  
IDPH License ID Number: 0011551  
Fiscal Year End: 12/31/2015

**Schedule 17A**

**XV. Balance Sheet**

**Line 9 Current Assets Other (specify):**

<b>Description</b>	<b>After</b>	
	<b>Operating</b>	<b>Consolidation</b>
Employee Uniform Purchases	2,432	2,432
Note due from CNA First	24,708	24,708
<b>Total - Line 9</b>	<b>27,140</b>	<b>27,140</b>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 838,555	1
2	Restatements (describe):		2
3	Prior period adjustment	26,909	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 865,464	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(124,180)	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)	\$ (124,180)	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)	\$ 741,284	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	\$ 4,605,032	1	
2	Discounts and Allowances for all Levels	(1,756,868)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,848,164	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	1,319,393	6	
7	Oxygen	47,118	7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,366,511	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	128,921	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory	15,652	19	
20	Radiology and X-Ray	5,536	20	
21	Other Medical Services	212,321	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 362,430	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	251	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 251	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	See Schedule 19A	46,217	28	
28a	See Schedule 19A	20,910	28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 67,127	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,644,483	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	1,049,021	31	
32	Health Care	1,759,177	32	
33	General Administration	901,258	33	
<b>B. Capital Expense</b>				
34	Ownership	369,151	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	506,987	35	
36	Provider Participation Fee	183,069	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,768,663	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(124,180)	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (124,180)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 588,588	44
45	Private Pay - Net Inpatient Revenue	2,361,560	45
46	Medicare - Net Inpatient Revenue	(164,394)	46
47	Other-(specify) Hospice	79,061	47
48	Other-(specify) See Schedule 19C	(16,651)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,848,164	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.

^ - Entity is a cash basis taxpayer.

**Facility Name:** Medina Nursing Center  
**IDPH License ID Number:** 0011551  
**Fiscal Year End:** 12/31/2015

**Schedule 19A**

**XVII. Income Statement**

**Line 28 Other Revenue (specify):**

<u>Description</u>	<u>Amount</u>
Equipment Rental - Private	5,924
Equipment Rental - Medicaid/PAC	17,062
Equipment Rental - Medicare A	3,594
Equipment Rental - HMO Managed Care	1,783
Equipment Rental - Hospice	15,550
Equipment Rental - VA	2,304
<b>Total - Line 28</b>	<b><u><u>46,217</u></u></b>

**XVII. Income Statement**

**Line 28a Other Expenses (specify):**

<u>Description</u>	<u>Amount</u>
Miscellaneous - Private	5,356
Miscellaneous - HMO Managed Care	54
Misc - VA	112
Miscellaneous Sales - Apt, Meals, Other	15,388
<b>Total - Line 37</b>	<b><u><u>20,910</u></u></b>

Facility Name: Medina Nursing Center  
IDPH License ID Number: 0011551  
Fiscal Year End: 12/31/2015

**Schedule 19C**

**XVII. Income Statement**

**Line 48 Net Inpatient Revenue detailed by Payer Source Other (specify):**

<u>Description</u>	<u>Amount</u>
Contractual Allowance - VA	(176,988)
Contractual Allowance - Outpatier	(228,595)
Room & Board	388,932
<b>Total - Line 48</b>	<b><u><u>(16,651)</u></u></b>

Facility Name & ID Number Medina Nursing Center

# 0011551

Report Period Beginning:

1/01/2015

Ending:

12/31/2015

**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	2,022	2,160	\$ 74,684	\$ 34.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,475	12,240	300,653	24.56	3
4	Licensed Practical Nurses	6,812	7,270	175,003	24.07	4
5	CNAs & Orderlies	55,990	58,910	672,821	11.42	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,531	7,082	96,994	13.70	10
11	Social Service Workers	4,080	4,320	92,480	21.41	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,160	45,428	21.03	13
14	Head Cook	7,844	8,343	77,703	9.31	14
15	Cook Helpers/Assistants	13,009	13,770	159,142	11.56	15
16	Dishwashers					16
17	Maintenance Workers	6,283	6,760	85,091	12.59	17
18	Housekeepers	9,507	10,118	110,442	10.92	18
19	Laundry	4,667	5,024	46,362	9.23	19
20	Administrator	3,120	3,240	137,800	42.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,105	6,543	102,001	15.59	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	3,900	4,297	83,276	19.38	31
32	Other Health Care					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,385	152,237	\$ 2,259,880 *	\$ 14.84	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	Monthly	\$ 7,819	1(3)	35
36	Medical Director	Monthly	15,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,780	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	12	922	11(3)	44
45	Social Service Consultant	16	1,197	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	28	\$ 29,318		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	31	\$ 1,278	10(3)	50
51	Licensed Practical Nurses	1,763	69,401	10(3)	51
52	Certified Nurse Assistants/Aides	2,346	52,808	10(3)	52
53	TOTAL (lines 50 - 52)	4,140	\$ 123,487		53



Facility Name: Medina Nursing Center  
IDPH License ID Number: 0011551  
Fiscal Year End: 12/31/2015

**Schedule 21A**

**XIX. SUPPORT SCHEDULES**

**C. Professional Services**

<u>Vendor</u>	<u>Type</u>	<u>Amount</u>
3-Cubed Inc	Computer Services	41,319
Ability Network Inc	Computer Services	3,750
Duane Morris LLP	Legal	9,303
eHealth Data Solutions	Computer Services	3,375
Infinisource, Inc	Computer Services	601
Point Click Care	Computer Services	16,602
Reno & Zahm LLP	Legal	7,273
RSM US LLP	Accounting	27,700
Sage Abra	Computer Services	2,843
<b>Total (agree to Schedule V, line 19, column 3)</b>		<u>112,766</u>
Less: Non-Allowable Legal Fees		(13,902)
<b>Total (agree to Schedule V, line 19, column 8)</b>		<u>98,864</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:

1/01/2015

Ending:

12/31/2015

## 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 - \$5,545
- (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? 5-10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 22,314 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. \$ 183,069  
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. \$ N/A 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? 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.