FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0011551

Facility Name: Medina Nursing Center, Inc.

Address: 402 Center Street (Number) Durand (City) 61024 (Zip Code)

County: Winnebago

Telephone Number: (815) 248-2151 **Fax #** (815) 248-2771

HFS ID Number:

Date of Initial License for Current Owners: 05/18/1965

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' PREPARATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	237	506	1,972	2,715	8
9	SNF/PED					9
10	ICF	14,250	7,837	0	22,087	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,487	8,343	1,972	24,802	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.35%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] 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 [X]

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 89 and days of care provided 1,972

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	260,165	24,105	8,097	292,367		292,367		292,367			1
2	Food Purchase		222,074		222,074		222,074	(5,436)	216,638			2
3	Housekeeping	100,673	34,575		135,248		135,248		135,248			3
4	Laundry	88,074	5,053		93,127		93,127		93,127			4
5	Heat and Other Utilities			86,908	86,908		86,908		86,908			5
6	Maintenance	23,040	22,620	46,455	92,115		92,115	4,555	96,670			6
7	Other (specify):*											7
8	TOTAL General Services	471,952	308,427	141,460	921,839		921,839	(881)	920,958			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	1,257,759	125,133	56,672	1,439,564		1,439,564		1,439,564			10
10a	Therapy		6,374	432,281	438,655		438,655		438,655			10a
11	Activities	58,007	3,481	10,530	72,018		72,018		72,018			11
12	Social Services	90,320		1,100	91,420		91,420		91,420			12
13	CNA Training	31,663	8,759	97,265	137,687		137,687		137,687			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,437,749	143,747	613,448	2,194,944		2,194,944		2,194,944			16
	C. General Administration											
17	Administrative	141,354			141,354		141,354		141,354			17
18	Directors Fees											18
19	Professional Services			129,055	129,055		129,055	(3,274)	125,781			19
20	Dues, Fees, Subscriptions & Promotions			16,457	16,457		16,457		16,457			20
21	Clerical & General Office Expenses	103,933	18,477	23,707	146,117		146,117		146,117			21
22	Employee Benefits & Payroll Taxes			370,290	370,290		370,290		370,290			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,098	13,098		13,098		13,098			24
25	Other Admin. Staff Transportation			12,483	12,483		12,483		12,483			25
26	Insurance-Prop.Liab.Malpractice			65,350	65,350		65,350		65,350			26
27	Other (specify):*											27
28	TOTAL General Administration	245,287	18,477	630,440	894,204		894,204	(3,274)	890,930			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,154,988	470,651	1,385,348	4,010,987		4,010,987	(4,155)	4,006,832			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, Inc. #0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			161,679	161,679		161,679	(2,107)	159,572			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			39,682	39,682		39,682	(133)	39,549			32
33	Real Estate Taxes			53,820	53,820		53,820		53,820			33
34	Rent-Facility & Grounds			32,800	32,800		32,800	(32,800)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			287,981	287,981		287,981	(35,040)	252,941			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		121,116		121,116		121,116		121,116			39
40	Barber and Beauty Shops	11,709	481		12,190		12,190		12,190			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,809	116,809		116,809		116,809			42
43	Other (specify):* Non-Allow Costs		2,007	97,884	99,891		99,891	(99,891)				43
44	TOTAL Special Cost Centers	11,709	123,604	214,693	350,006		350,006	(99,891)	250,115			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,166,697	594,255	1,888,022	4,648,974		4,648,974	(139,086)	4,509,888			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, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,436)	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	(7,175)	30		9
10	Interest and Other Investment Income	(133)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(34,723)	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 Pg 5A	(63,887)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (111,354)		$	30

BHF USE ONLY								
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 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(27,732)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (27,732)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (139,086)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Medina Nursing Center, Inc.

ID# **0011551**

Report Period Beginning: **01/01/11**

Ending: **12/31/11**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs	$ (3,511)	43	1
2	X-Rays	(2,255)	43	2
3	Personal Supplies	(971)	43	3
4	Legal	(3,274)	19	4
5	Non-Covered Meds	(1,036)	43	5
6	PAC Donations	(7,031)	43	6
7	Standing Costs	(55,993)	43	7
8	Gain/Loss on disposal of FA	17,610	43	8
9	Apartment	(1,030)	43	9
10	Internet Costs	(5,585)	43	10
11	Goodwill	(5,416)	43	11
12	Reconciliation Discrepencies	50	43	12
13	Reclassify Repair & Maintenance	4,555	6	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
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29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(63,887)		49

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Medina Manor Building, Inc.	0.00%	$ 5,068	$ 5,068	1
2	V	34	Rent	32,800	Medina Manor Building, Inc.	0.00%		(32,800)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 32,800			$ 5,068	$ * (27,732)	14

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

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Holgeir Oksnevad	President	Administrator	100.00	none	50+	100.00	Salary	$ 141,354	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	$ 141,354		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, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 [X]

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

Name of Related Organization
Street Address NA
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Durand Bank		X	Vehicle Loan	$372.94	05/29/09	$ 12,150	$	05/29/12	0.0650	$ 179	1
2	Durand Bank		X	Mediana Building Loan	$9,222.00	06/15/11	1,289,648	1,289,648	06/15/16	0.0595	27,116	2
3												3
4												4
5												5
	Working Capital											
6												6
7	Durand Bank		X	Working Capital	None	08/14/10	350,000		08/14/11	0.0500	12,387	7
8	Holgeir Oksnevad	X		Working Capital	None	Varies	Varies	54,744	Demand	None		8
9	TOTAL Facility Related				$9,594.94		$ 1,651,798	$ 1,344,392			$ 39,682	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13								Interest Income Offset			(133)	13
14	TOTAL Non-Facility Related						$	$			$ (133)	14
15	TOTALS (line 9+line14)						$ 1,651,798	$ 1,344,392			$ 39,549	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.)**

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 55,000	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.)	2010	$ 53,220	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,780)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 55,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 53,820	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	44,917	8
2007	45,996	9
2008	50,530	10
2009	51,920	11
2010	53,220	12

2010 RE Taxes $53,220
Est Incr for 2011 3.35%
Computed Total $55,000.58
Will use $55,600

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2010 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-15-251-001	Medina Manor Building	$ 1,109.00	$ 1,109.00
2.	05-15-251-002	Medina Manor Building	$ 50,977.00	$ 50,977.00
3.	05-15-251-003	Medina Manor Building	$ 1,134.00	$ 1,134.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 53,220.00	$ 53,220.00

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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 [X] (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	Resident Care	7 acres	1965	$ 3,048	1
2					2
3	TOTALS	7 acres		$ 3,048	3

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1965	1965	$ 488,644	$	30	$	$	$ 488,644	4
5	25		1980	1980	158,173		30			158,173	5
6											6
7		Allocated from Medina Manor Building Fund						5,068	5,068		7
8											8
	Improvement Type**										
9	Building Improvements			1968	675		15			675	9
10	Building Improvements			1974	861		10			861	10
11	Building Improvements			1975	1,547		10			1,547	11
12	Building Improvements			1976	345		9			345	12
13	Building Improvements			1977	12,614		21			12,614	13
14	Building Improvements			1977	2,793		8			2,793	14
15	Building Improvements			1979	2,620		7			2,620	15
16	Building Improvements			1980	24,465		20			24,465	16
17	Building Improvements			1980	2,137		7			2,137	17
18	Building Improvements			1981	20,211		15			20,211	18
19	Building Improvements			1982	2,305		20			2,305	19
20	Building Improvements			1983	705		5			705	20
21	Building Improvements			1985	980		10			980	21
22	Building Improvements			1985	3,091		20			3,091	22
23	Building Improvements			1986	17,543		10			17,543	23
24	Building Improvements			1987	56,373		20			56,373	24
25	Building Improvements			1988	14,212		20			14,212	25
26	Building Improvements			1989	30,063		20			30,063	26
27	Building Improvements			1990	1,601		20			1,601	27
28	Building Improvements			1991	51,619	1,147	20	1,290	143	51,619	28
29	Building Improvements			1991	11,626		20	581	581	11,332	29
30	Building Improvements			1992	39,070	2,605	20	1,954	(651)	36,147	30
31	Building Improvements			1992	3,295	203	20	165	(38)	3,215	31
32	Building Improvements			1992	19,372		20	969	969	18,893	32
33	Building Improvements			1992	23,809	2,362	20	1,190	(1,172)	23,205	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	
37	Building Improvements	1993	$ 37,059	$ 2,471	20	$ 1,853	$ (618)	$ 34,283	37
38	Building Improvements	1993	100,000		20	5,000	5,000	91,699	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	47,164	39
40	Building Improvements	1994	15,610		10			15,610	40
41	Building Improvements	1995	47,826		15	(1,589)	(1,589)	47,826	41
42	Building Improvements	1995	36,144		15			36,144	42
43	Outdoor Signs	1996	2,149	75	15	75		2,149	43
44	Backflow Preventors	1996	3,679	126	15	126		3,679	44
45	Garbage Disposal (disposed in 2010)	1996							45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		550	46
47	Door	1997	1,996	133	15	133		1,929	47
48	Sign	1997	666	44	15	44		639	48
49	Air Conditioner	1997	3,500	233	15	233		3,379	49
50	Lights	1997	621	41	15	41		595	50
51	Driveway	1997	2,875	192	15	192		2,784	51
52	Fire Alarm	1997	1,246	83	15	83		1,204	52
53	Plumbing	1997	5,122	341	15	341		4,945	53
54	Telephone System	1997	1,152	77	15	77		1,092	54
55	Permanent Outdoor Receptacles	1997	585	39	15	39		566	55
56	Office Remodeling	1998	2,454	164	15	164		2,214	56
57	Exterior Doors	1998	7,652	510	15	510		6,885	57
58	Windows	1998	15,536	1,036	15	1,036		13,986	58
59	Roof Repair	1998	2,317	154	15	154		2,079	59
60	Water and Sewer Improvements	1998	3,165	211	15	211		2,847	60
61	Fire Alarm	1998	1,157	77	15	77		1,020	61
62	Telephone System	1998	1,467	98	15	98		1,321	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,341,159	$ 15,807		$ 22,979	$ 7,172	$ 1,312,958	70

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

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 12A, Carried Forward		$ 1,341,159	$ 15,807		$ 22,979	$ 7,172	$ 1,312,958	1
2	Blinds	1999	3,689	246	15	246		3,073	2
3	Window Replacement	1999	5,145	305	15	343	38	4,288	3
4	Rewire & Replumb Laundry Room	1999	7,824	481	15	522	41	6,519	4
5	Floor Tile	1999	1,049	70	15	70		875	5
6	Air Conditioning	1999	1,895	126	15	126		1,575	6
7	Boiler	1999	535	36	15	36		444	7
8	Sidewalk	2000	1,386	92	15	92		1,058	8
9	Kickplates	2000	608	41	15	41		466	9
10	Landscaping Brick	2000	1,139	76	15	76		874	10
11	Blacktop Parking Lot	2001	15,000	1,000	15	1,000		10,500	11
12	Dumpster Gate Frames	2001	1,650	110	15	110		1,155	12
13	Dumpster Concrete Platform	2001	3,700	247	15	247		2,593	13
14	Stone Wall	2001	1,665	111	15	111		1,165	14
15	Video Surveillance	2002	14,865	991	15	991		9,415	15
16	Wrought Iron Fence	2002	5,105	340	15	340		3,230	16
17	Nurses Call System	2002	12,726	848	15	848		8,056	17
18	Custom Doors	2002	9,427	628	15	628		5,966	18
19	Windows Framing	2003	11,656	777	15	777		6,605	19
20	Roof	2003	7,470	498	15	498		4,233	20
21	Alarm Installation	2003	12,730	849	15	849		7,216	21
22	Cabinets	2004	504	34	15	34		255	22
23	Surveillance Cameras	2004	578	39	15	39		291	23
24	Time Clock	2004	10,000	667	15	667		5,001	24
25	Latches	2004	8,923	595	15	595		4,461	25
26	Exhaust Hood	2004	4,290	286	15	286		2,145	26
27	Bath Call Light	2004	1,229	82	15	82		615	27
28	Ventilator	2004	1,038	69	15	69		519	28
29	Driveway	2004	4,000	267	15	267		2,001	29
30	Sidewalk & Driveway	2005	5,209	347	15	347		2,255	30
31	Wiring & Outlets	2005	8,903	594	15	594		3,860	31
32	Windows	2005	1,911	127	15	127		826	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,507,008	$ 26,786		$ 34,037	$ 7,251	$ 1,414,493	34

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

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 12B, Carried Forward		$ 1,507,008	$ 26,786		$ 34,037	$ 7,251	$ 1,414,493	1
2	Flag Poles	2005	4,362	291	15	291		1,891	2
3									3
4	Fire Alarm System	2006	12,455	415	15	830	415	4,565	4
5	Doors and Gaskets	2006	6,545	218	15	436	218	2,398	5
6	Water Softner	2006	965	32	15	64	32	352	6
7	Landscaping Improvements	2006	2,377	79	15	158	79	869	7
8	Timeclock	2006	20,715	691	15	1,382	691	7,601	8
9	Roofing	2006	1,350	45	15	90	45	495	9
10	Fire Door	2006	965	32	15	64	32	351	10
11	Hot Water Storage Tank	2006	11,998	400	15	800	400	4,400	11
12	A/C Compressor	2006	1,777	59	15	118	59	649	12
13	Fire Alarm Panel	2006	3,200	107	15	214	107	1,177	13
14									14
15	Roofing	2007	2,675	178	15	178		801	15
16	Fire Safety Doors	2007	3,111	207	15	207		932	16
17	Kitchen Cabinets	2007	4,131	275	15	275		1,238	17
18	Water Treatment System	2007	11,465	764	15	764		3,438	18
19	Timeclock system	2007	4,034	269	15	269		1,210	19
20									20
21	Sprinkler	2008	33,686	2,246	15	2,246		7,861	21
22	Tub room improvements	2008	20,275	1,352	15	1,352		4,732	22
23	Generator	2008	44,840	2,990	15	2,990		10,465	23
24	Wiring	2008	12,182	812	15	812		2,842	24
25	Pipe Insulation	2008	6,807	454	15	454		1,589	25
26	Fire Stops	2008	4,368	292	15	292		1,022	26
27	Sidewalk replacement	2008	4,805	320	15	320		1,120	27
28	Dining Room Doors	2008	8,397	560	15	560		1,960	28
29	Ceiling work	2008	4,374	292	15	292		1,022	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,738,867	$ 40,166		$ 49,495	$ 9,329	$ 1,479,473	34

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

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 12C, Carried Forward		$ 1,738,867	$ 40,166		$ 49,495	$ 9,329	$ 1,479,473	1
2	Ceiling Work - North/Center Hall	2009	25,166	1,678	15	1,888	210	4,405	2
3	A/C West Hall	2009	87,956	5,864	15	6,597	733	15,393	3
4	Built in Cabinets	2009	4,851	323	15	364	41	849	4
5	A/C Dining Room	2009	8,500	567	15	637	70	1,487	5
6	Fire Alarm	2009	2,607	174	15	196	22	457	6
7	Sprinkler	2009	5,260	351	15	394	43	920	7
8	Carpet	2009	4,988	998	5	1,372	374	2,869	8
9									9
10	A/C Project - Center Hall	2010	79,527	5,302	15	5,302		7,953	10
11	A/C Project - North Hall	2010	51,265	3,418	15	3,418		5,127	11
12	Sprinkler System	2010	42,195	2,813	15	2,813		4,220	12
13	Updating - Center Hall	2010	55,277	3,685	15	3,685		5,528	13
14	A/C Project - Downstairs	2010	66,718	4,448	15	4,448		6,672	14
15	South Hall A/C	2010	31,149	2,077	15	2,077		3,115	15
16	Final - Sprinkler System	2010	7,060	471	15	471		706	16
17	Updating - Center Hall	2010	38,562	2,571	15	2,571		3,856	17
18	Updating - Downstairs	2010	21,568	1,438	15	1,438		2,157	18
19	Updating - North Hall	2010	15,151	1,010	15	1,010		1,515	19
20	Updating - South Hall	2010	26,058	1,737	15	1,737		2,606	20
21	Transfer from CIP	2010	84,287	5,619	15	5,619		8,429	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	$ 84,710		$ 95,532	$ 10,822	$ 1,557,737	34

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

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 12D, Carried Forward		$ 2,397,012	$ 84,710		$ 95,532	$ 10,822	$ 1,557,737	1
2	Lower level A/C Installation	2011	61,000	2,033	15	2,033		2,033	2
3	South hall A/C work Installation	2011	33,464	1,115	15	1,115		1,115	3
4	Updated-South hall eletrical and Plumbing	2011	60,338	1,508	20	1,508		1,508	4
5	Updated-North hall bathroom-flooring,paint and electrical	2011	9,626	241	20	241		241	5
6	Updated-Landscaping	2011	13,853	693	10	693		693	6
7	Updated West hall-Bathroom and water softner	2011	4,043	101	20	101		101	7
8	Downstairs bathrooms-Flooring,plumbing	2011	11,187	280	20	280		280	8
9	Addition to Sprinkler- south hall	2011	8,135	203	20	203		203	9
10	Heating equipment Installation on lower level	2011	21,929	548	20	548		548	10
11	North hall flooring	2011	11,519	288	20	288		288	11
12	Updated Outside leasehold courtyard- benches,garden	2011	12,571	629	10	629		629	12
13	Updated and replaced Roof & gutters	2011	80,797	4,040	10	4,040		4,040	13
14	Updated South hall bathroom-Flooring,door,windows	2011	16,442	411	20	411		411	14
15	Dialysis project retrofit room	2011	25,000	833	15	833		833	15
16	Ozone unit for washing machines	2011	17,000	850	10	850		850	16
17	Water softener	2011	10,939	273	20	273		273	17
18	Water heater system installed including plumbing and piping	2011	41,466	1,382	15	1,382		1,382	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)		$ 2,836,320	$ 100,138		$ 110,960	$ 10,822	$ 1,573,165	34

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

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 524,536	$ 44,496	$ 31,567	$ (12,929)	5-10	$ 318,160	71
72	Current Year Purchases	26,158	1,404	1,404		7-15	1,404	72
73	Fully Depreciated Assets	197,231					197,231	73
74								74
75	TOTALS	$ 747,925	$ 45,900	$ 32,971	$ (12,929)		$ 516,795	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	from Schedule 13A	Various	Various	143,891	15,641	15,641			115,263	78
79										79
80	TOTALS			$ 171,308	$ 15,641	$ 15,641	$		$ 142,680	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,758,601	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 161,679	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 159,572	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,107)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,232,640	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
1/1/2011 to 12/31/2011 Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Maintenance	2005 Ford Freestar	2005	8,436	71	71	-	5	8,436
Administrative	2006 Mercedes	2005	64,062	1,829	1,829		5	64,062
Maintenance	Forklift	2007	6,000	1,200	1,200	-	5	5,400
Maintenance	Kubota RTV	2007	15,700	3,140	3,140	-	5	14,130
Administrative	2006 Dodge Van	2009	18,207	3,641	3,641	-	5	9,103
Administrative	2006 Ford Bus	2009	15,506	3,101	3,101	-	5	7,753
Maintenance	1999 Dodge Truck	2009	10,612	2,122	2,122	-	5	5,305
Maintenance	Trailer	2010	5,368	537	537		5	1,074
TOTAL			143,891	15,641	15,641	-	40	115,263

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

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

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ _____ Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		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, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER CNA 80

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			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)		31,663		31,663
6	Transportation					
7	Contractual Payments					
8	Other Non-Salary Expenses			106,024		106,024
9	TOTALS		$	$ 137,687	$	$ 137,687
10	SUM OF line 9, col. 1 and 2	(e)	$ 137,687			

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	1
2. From other facilities (f)	86
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	87

(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: 12/31/11

Schedule 15A

Schedule XV
Income Statement

Line 13A- CNA's

Account Description	Drop Outs	Completed	Contracted	Total
Training Coordinator		2,141		2,141
CNA First Office Supply		1,309		1,309
RN Instructor		36,425		36,425
CPR Instructor		3,359		3,359
CNA First Rent		36,000		36,000
CNA First General Advertising		11,734		11,734
CNA First Physicals		1,483		1,483
CNA First Background Checks		3,973		3,973
Bank Charges		1,274		1,274
Professional (legal, consultants.)		753		753
Text Books		6,849		6,849
Travel		722		722
		106,023	**-**	**106,023**

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10(A)3	hrs	$	1,603	$ 115,373	$	1,603	$ 115,373	1
2	Licensed Speech and Language Development Therapist	10(A)3	hrs		739	53,225		739	53,225	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10(A)3	hrs		3,662	263,683	6,374	3,662	270,057	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				121,116		121,116	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			$	6,004	$ 432,281	$ 127,490	6,004	$ 559,771	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.

STATE OF ILLINOIS

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 138,652	$ 138,662	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 55,000)	1,368,282	1,368,282	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): See Sch 17A	77,598	77,598	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,592,343	$ 1,592,353	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,048	13
14	Buildings, at Historical Cost		646,816	14
15	Leasehold Improvements, at Historical Cost	1,980,924	2,189,504	15
16	Equipment, at Historical Cost	1,008,651	919,233	16
17	Accumulated Depreciation (book methods)	(1,329,999)	(2,232,640)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,659,576	$ 1,525,961	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,251,919	$ 3,118,314	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 334,055	$ 334,055	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	34,875	34,875	29
30	Accrued Salaries Payable	6,864	6,864	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,359	26,359	31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,600	55,600	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued provider tax	68,081	68,081	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 525,834	$ 525,834	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,309,517	1,309,517	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,309,517	$ 1,309,517	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,835,351	$ 1,835,351	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,416,568	$ 1,282,963	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,251,919	$ 3,118,314	48

*(See instructions.)

Medina Nursing Center, Inc.
Provider # 0011551
FYE: 12/31/11 Schedule 17A

Summary of Other Assets (Line #17):

Acct. #	Account Name	Operating	After Consolidation
12390-00-0000	Employee Advances	4,724	4,724
18005-10-0000	Note due from apartments	72,874	72,874
	Total Other Assets	77,598	77,598

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,193,414	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,193,414	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	223,154	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)**	$ 223,154	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,416,568	24 *

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

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,395,795	1
2	Discounts and Allowances for all Levels	(1,844,861)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,550,934	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,638,764	6
7	Oxygen	53,770	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,692,534	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	104,312	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	137,933	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,055	19
20	Radiology and X-Ray	1,679	20
21	Other Medical Services	264,073	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 512,052	23
	D. Non-Operating Revenue		
24	Contributions	10,000	24
25	Interest and Other Investment Income***	133	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,133	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	101,141	28
28a	See Schedule 19A	5,334	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 106,475	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,872,128	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	921,839	31
32	Health Care	2,194,944	32
33	General Administration	894,204	33
	B. Capital Expense		
34	Ownership	287,981	34
	C. Ancillary Expense		
35	Special Cost Centers	233,197	35
36	Provider Participation Fee	116,809	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,648,974	40
41	**Income before Income Taxes (line 30 minus line 40)****	223,154	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 223,154	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
Entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

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

Medina Nursing Center, Inc.
Provider # 0011551
FYE: 12/31/11 Schedule 19A

Summary of Other Revenue Line 28:

30010-00-0000	30010 Equipment Rental	12,439
31010-00-0000	31010 Equipment Rental	49,017
32010-00-0000	32010 Equipment Rental	16,096
34010-00-0000	34010 Equipment Rental	2,692
35010-00-0000	35010 Equipment Rental	20,897
	Total Other Revenue	101,141

Summary of Other Revenue Line 28A:

30013-00-0000	30013 Miscellaneous	(732)
34013-00-0000	34013 Miscellaneous	78
38003-00-0000	Miscellaneous	6,168
38004-00-0000	Uniform Sales	(180)
	Total Other Revenue	5,334
		106,475

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 74,825	$ 35.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,269	14,297	285,384	19.96	3
4	Licensed Practical Nurses	9,816	10,467	202,659	19.36	4
5	CNAs & Orderlies	53,069	56,367	670,850	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,946	2,117	27,073	12.79	9
10	Activity Assistants	2,772	2,970	30,934	10.42	10
11	Social Service Workers	4,082	4,346	90,320	20.78	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	39,260	18.88	13
14	Head Cook	3,047	3,321	68,429	20.61	14
15	Cook Helpers/Assistants	17,637	18,822	152,476	8.10	15
16	Dishwashers					16
17	Maintenance Workers	1,761	1,852	23,040	12.44	17
18	Housekeepers	7,473	8,028	100,673	12.54	18
19	Laundry	7,606	8,088	88,074	10.89	19
20	Administrator	3,000	3,120	141,354	45.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,794	8,281	103,933	12.55	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	1,937	2,112	24,041	11.38	31
32	Other Health C: CNA Training Coo	1,816	1,986	31,663	15.94	32
33	Other(specify) Beautician	1,004	1,146	11,709	10.22	33
34	TOTAL (lines 1 - 33)	141,949	151,480	$ 2,166,697 *	$ 14.30	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	171	$ 8,097	1(3)	35
36	Medical Director	Monthly	15,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	7	1,500	10(3)	38
39	Pharmacist Consultant	Monthly	4,622	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	16	1,100	11(3)	44
45	Social Service Consultant	16	1,100	12(3)	45
46	Other(specify)				46
47	CPR Instructor	62	2,214	10(3)	47
48	Computer Consultant	198	12,673	21(3)	48
49	TOTAL (lines 35 - 48)	470	$ 46,906		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	460	$ 18,783	10(3)	50
51	Licensed Practical Nurses	146	6,076	10(3)	51
52	Certified Nurse Assistants/Aides	1,100	25,691	10(3)	52
53	TOTAL (lines 50 - 52)	1,706	$ 50,550		53

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Holgeir Oksnevad	Administrator	100	$ 141,354
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 141,354

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Sch 21A		$ 129,055
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 129,055

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,870
Unemployment Compensation Insurance	13,823
FICA Taxes	166,186
Employee Health Insurance	88,301
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	43,613
Employee Relations	8,464
Employee Physicals	862
Wellness	171
TOTAL (agree to Schedule V, line 22, col.8)	$ 370,290

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	2,025
Health Care Worker Background Check	
(Indicate # of checks performed 31)	495
Patient Background Checks 84	1,344
Miscellaneous License & Dues	1,607
IHCA Dues	4,667
Miscellaneous Dues & Subscriptions	1,195
IL Secretary of State License	504
License Plates	640
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,457

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	13,098
See attached schedule	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,098

* Attach copy of IMRF notifications

**See instructions.

Medina Nursing Center, Inc.
Provider #0011551
FYE: 12/31/11

Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount	
McGladrey & Pullen	Accounting	31,880	
RENO & ZAHM LLP	Legal	3,274	
Duane Morris	Legal	63,935	
Point Click Care	Computer Services	15,823	
Ivans, Inc	Computer Services	589	
eHealth Data Solutions	Computer Services	2,700	
Dresser & Associates	Computer Services	2,200	
EMPOWER SOFTWARE SOLUTIONS, II	Computer Services	1,877	
Qqest Software Systems	Computer Services	6,445	
Microsoft Store	Computer Services	159	
FR&R H/Care Consulting	Computer Services	173	
Total		129,055	- Ties to Line #19, Col #3
Less: Nonallowable Legal		(3,274)	
Adjusted Total		125,781	- Ties to Line #19, Col #8

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3									N/A				
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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 - 4667**

(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? **11 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,109** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **116,809**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,168**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **N/A** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.