FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

I. IDPH License ID Number: 0011551

Facility Name: Medina Nursing Center, Inc.

Address: 402 South 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: Amanda Springborn **Telephone Number:** (314) 925-3838
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 1/1/18 to 12/31/18 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) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US 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: 1/1/18 Ending: 12/31/18

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		296	1,528	1,824	8
9	SNF/PED					9
10	ICF	14,374	5,929	3,057	23,360	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,374	6,225	4,585	25,184	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.53%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve 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 1,169

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 **Report Period Beginning:** 1/1/18 **Ending:** 12/31/18

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	281,596	20,599	5,769	307,964		307,964	-	307,964			1
2	Food Purchase		235,522		235,522		235,522	(2,725)	232,797			2
3	Housekeeping	107,615	41,110	-	148,725		148,725	-	148,725			3
4	Laundry	39,901	10,165	-	50,066		50,066	-	50,066			4
5	Heat and Other Utilities			87,506	87,506		87,506	-	87,506			5
6	Maintenance	86,571	14,372	110,997	211,940		211,940	(16,093)	195,847			6
7	Other (specify):*	-	-	-				-				7
8	**TOTAL General Services**	515,683	321,768	204,272	1,041,723		1,041,723	(18,818)	1,022,905			8
	B. Health Care and Programs											
9	Medical Director	-	-	15,600	15,600		15,600	-	15,600			9
10	Nursing and Medical Records	1,410,574	109,799	235,081	1,755,454		1,755,454	-	1,755,454			10
10a	Therapy	-	-	-				-				10a
11	Activities	62,814	1,806	5,294	69,914		69,914	-	69,914			11
12	Social Services	75,578	-	4,003	79,581		79,581	-	79,581			12
13	CNA Training	30,040	-	6,759	36,799		36,799	-	36,799			13
14	Program Transportation	-	-	-				-				14
15	Other (specify):*	-	-	-				-				15
16	**TOTAL Health Care and Programs**	1,579,006	111,605	266,737	1,957,348		1,957,348		1,957,348			16
	C. General Administration											
17	Administrative	137,800	-	-	137,800		137,800	-	137,800			17
18	Directors Fees			-				-				18
19	Professional Services			74,840	74,840		74,840	(8,896)	65,944			19
20	Dues, Fees, Subscriptions & Promotions			14,857	14,857		14,857	(1,904)	12,953			20
21	Clerical & General Office Expenses	103,928	14,998	35,366	154,292		154,292	(8,157)	146,135			21
22	Employee Benefits & Payroll Taxes			491,586	491,586		491,586	-	491,586			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			12,487	12,487		12,487	(5,746)	6,741			24
25	Other Admin. Staff Transportation		-	5,430	5,430		5,430	-	5,430			25
26	Insurance-Prop.Liab.Malpractice			72,188	72,188		72,188	-	72,188			26
27	Other (specify):*	-	-	-				-				27
28	**TOTAL General Administration**	241,728	14,998	706,754	963,480		963,480	(24,703)	938,777			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,336,417	448,371	1,177,763	3,962,551		3,962,551	(43,521)	3,919,030			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: 1/1/18 Ending: 12/31/18

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			171,530	171,530		171,530	10,449	181,979			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			93,193	93,193		93,193	(16,573)	76,620			32
33	Real Estate Taxes			56,954	56,954		56,954	(1,496)	55,458			33
34	Rent-Facility & Grounds			8,700	8,700		8,700	(8,700)				34
35	Rent-Equipment & Vehicles			4,752	4,752		4,752	-	4,752			35
36	Other (specify):*			-				-				36
37	**TOTAL Ownership**			335,129	335,129		335,129	(16,320)	318,809			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	117,255	350,955	468,210		468,210	(126,604)	341,606			39
40	Barber and Beauty Shops	-	-	14,641	14,641		14,641	-	14,641			40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			214,113	214,113		214,113	-	214,113			42
43	Other (specify):* Non-Allowable Cos	47,680	-	32,360	80,040		80,040	(80,040)				43
44	**TOTAL Special Cost Centers**	47,680	117,255	612,069	777,004		777,004	(206,644)	570,360			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,384,097	565,626	2,124,961	5,074,684		5,074,684	(266,485)	4,808,199			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: 1/1/18 Ending: 12/31/18

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	(2,725)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,155)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,259	30		9
10	Interest and Other Investment Income	(16,573)	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	(2,557)	43		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	(7,650)	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 PG5A	(227,711)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (261,112)		$	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)	(5,373)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (5,373)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (266,485)		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

Medina Nursing Center, Inc.

ID# 0011551

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs	$ (3,957)	43	1
2	X-Rays	(2,317)	43	2
3	Goodwill	(3,646)	43	3
4	Gain/Loss on Disposal of Assets	4	43	4
5	Nonallowable Legal	(8,896)	19	5
6	To Disallow nonallowable dialysis	(125)	39	6
7	Miscellaneous income	(8,294)	21	7
8	Lobbying Expense	(1,904)	20	8
9	Admissions	(47,681)	43	9
10	Therapy	(126,479)	39	10
11	Legal collections	(1,082)	43	11
12	Real Estate	(1,496)	33	12
13	Capitalized repairs	(16,093)	6	13
14	Nonallowable Seminar	(5,746)	24	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(227,711)		49

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

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%	$ 3,190	$ 3,190	1
2	V	21	Miscellaneous expense		Medina Manor Building, Inc.	0.00%	137	137	2
3	V	34	Rent	8,700	Medina Manor Building, Inc.	0.00%		(8,700)	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			$ 8,700			$ 3,327	$ * (5,373)	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: 1/1/18 Ending: 12/31/18

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	40	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, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

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
City / State / Zip Code N/A
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	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 & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	Medina Building Loan	$ 9,222.00	06/15/11	$ 1,097,980	$ 997,762	11/30/2021	0.05950	$ 61,966	1
2	Durand State Bank		X	Van	658.22	11/16/17	35,175	28,214	11/16/2022	0.04590	1,391	2
3												3
4												4
5												5
	Working Capital											
6	Davis Bank		X	Working Capital	None	6/27/12	400,000	305,618	01/30/2019	0.05000	8,786	6
7	Durand Bank		X	Working Capital	None	08/14/12	650,000	482,145	11/30/2019	0.05375	20,901	7
8	H. Oksnevad	X		Working Capital	None	Varies	Varies	135,000	Demand	None	149	8
9	TOTAL Facility Related				$9,880.22		$ 2,183,155	$ 1,948,739			$ 93,193	9
	B. Non-Facility Related*											
10												10
11								Finance Charges			(94)	11
12								Offset interest income			(16,479)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (16,573)	14
15	TOTALS (line 9+line14)						$ 2,183,155	$ 1,948,739			$ 76,620	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: 1/1/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 62,000	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.)	2017	$ 56,954	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,046)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 62,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	Prior period tax adjustmer (1,496)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 55,458	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	59,602	8
	2014	59,412	9
	2015	59,482	10
	2016	60,371	11
	2017	56,954	12

2017 RE Taxes $56,954; Est Increase for 2018 is 1%
56,954*1.01= 57,524
Will use $62,000

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-15-251-003	Medina Manor Building	$ 1,213.16	$ 1,213.16
2.	05-15-251-008	Medina Manor Building	$ 1,187.12	$ 1,187.12
3.	05-15-251-009	Medina Manor Building	$ 54,554.20	$ 54,554.20
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 56,954.48	$ 56,954.48

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 1/1/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24000 B. General Construction Type: Exterior Brick Frame Masonry, Fire Resort 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. [X] (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 [X] 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	304,920	1965	$ 3,048	1
2					2
3	TOTALS	304,920		$ 3,048	3

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

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			3,190	3,190		7
8						-		-			8
	Improvement Type**										
9	Building Improvements		1968	1968	675	-	15	-		675	9
10	Building Improvements		1974	1974	861	-	10	-		861	10
11	Building Improvements		1975	1975	1,547	-	10	-		1,547	11
12	Building Improvements		1976	1976	345	-	9	-		345	12
13	Building Improvements		1977	1977	12,614	-	21	-		12,614	13
14	Building Improvements		1977	1977	2,793	-	8	-		2,793	14
15	Building Improvements		1979	1979	2,620	-	7	-		2,620	15
16	Building Improvements		1980	1980	24,465	-	20	-		24,465	16
17	Building Improvements		1980	1980	2,137	-	7	-		2,137	17
18	Building Improvements		1981	1981	20,211	-	15	-		20,211	18
19	Building Improvements		1982	1982	2,305	-	20	-		2,305	19
20	Building Improvements		1983	1983	705	-	5	-		705	20
21	Building Improvements		1985	1985	980	-	10	-		980	21
22	Building Improvements		1985	1985	3,091	-	20	-		3,091	22
23	Building Improvements		1986	1986	17,543	-	10	-		17,543	23
24	Building Improvements		1987	1987	56,373	-	20	-		56,373	24
25	Building Improvements		1988	1988	14,212	-	20	-		14,212	25
26	Building Improvements		1989	1989	30,063	-	20	-		30,063	26
27	Building Improvements		1990	1990	1,601	-	20	-		1,601	27
28	Building Improvements		1991	1991	51,619	-	20	-		51,619	28
29	Building Improvements		1991	1991	11,626	-	20	-		11,626	29
30	Building Improvements		1992	1992	39,070	-	20	-		39,070	30
31	Building Improvements		1992	1992	3,295	-	20	-		3,295	31
32	Building Improvements		1992	1992	19,372	-	20	-		19,372	32
33	Building Improvements		1992	1992	23,809	-	20	-		23,809	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: 1/1/18 Ending: 12/31/18

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	$ 37,058	$ -	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	TOTAL (lines 4 thru 69)		$ 1,341,158	$		$ 3,190	$ 3,190	$ 1,341,158	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: 1/1/18 Ending: 12/31/18

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		$ 1,341,158	$		$ 3,190	$ 3,190	$ 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	-	15			1,386	8
9	Kickplates	2000	608	-	15			608	9
10	Landscaping Brick	2000	1,139	-	15			1,139	10
11	Blacktop Parking Lot	2001	15,000	-	15			15,000	11
12	Dumpster Gate Frames	2001	1,650	-	15			1,650	12
13	Dumpster Concrete Platform	2001	3,700	-	15			3,700	13
14	Stone Wall	2001	1,665	-	15			1,665	14
15	Video Surveillance	2002	14,865	-	15			14,865	15
16	Wrought Iron Fence	2002	5,105	-	15			5,105	16
17	Nurses Call System	2002	12,726	-	15			12,726	17
18	Custom Doors	2002	9,427	-	15			9,427	18
19	Windows Framing	2003	11,656	388	15	388		11,656	19
20	Roof	2003	7,470	249	15	249		7,470	20
21	Alarm Installation	2003	12,730	424	15	424		12,730	21
22	Cabinets	2004	504	34	15	34		488	22
23	Surveillance Cameras	2004	578	39	15	39		560	23
24	Time Clock	2004	10,000	667	15	667		9,668	24
25	Latches	2004	8,923	595	15	595		8,626	25
26	Exhaust Hood	2004	4,290	286	15	286		4,147	26
27	Bath Call Light	2004	1,229	82	15	82		1,188	27
28	Ventilator	2004	1,038	69	15	69		1,002	28
29	Driveway	2004	4,000	267	15	267		3,867	29
30	Sidewalk & Driveway	2005	5,209	347	15	347		4,687	30
31	Wiring & Outlets	2005	8,903	594	15	594		8,014	31
32	Windows	2005	1,911	127	15	127		1,719	32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 1,507,007	$ 4,168		$ 7,358	$ 3,190	$ 1,504,388	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: 1/1/18 Ending: 12/31/18

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		$ 1,507,007	$ 4,168		$ 7,358	$ 3,190	$ 1,504,388	1
2	Flag Poles	2005	4,362	291	15	291		3,926	2
3				-		-		-	3
4	Fire Alarm System	2006	12,455	830	15	830		10,378	4
5	Doors and Gaskets	2006	6,545	436	15	436		5,453	5
6	Water Softner	2006	965	64	15	64		803	6
7	Landscaping Improvements	2006	2,377	158	15	158		1,980	7
8	Timeclock	2006	20,715	1,381	15	1,381		17,263	8
9	Roofing	2006	1,350	90	15	90		1,125	9
10	Fire Door	2006	965	64	15	64		803	10
11	Hot Water Storage Tank	2006	11,998	800	15	800		9,999	11
12	A/C Compressor	2006	1,777	118	15	118		1,479	12
13	Fire Alarm Panel	2006	3,200	213	15	213		2,666	13
14				-		-		-	14
15	Roofing	2007	2,675	178	15	178		2,050	15
16	Fire Safety Doors	2007	3,111	207	15	207		2,384	16
17	Kitchen Cabinets	2007	4,131	275	15	275		3,166	17
18	Water Treatment System	2007	11,465	764	15	764		8,789	18
19	Timeclock system	2007	4,034	269	15	269		3,093	19
20				-		-		-	20
21	Sprinkler	2008	33,686	2,246	15	2,246		23,581	21
22	Tub room improvements	2008	20,275	1,352	15	1,352		14,194	22
23	Generator	2008	44,840	2,989	15	2,989		31,387	23
24	Wiring	2008	12,182	812	15	812		8,527	24
25	Pipe Insulation	2008	6,807	454	15	454		4,766	25
26	Fire Stops	2008	4,368	291	15	291		3,057	26
27	Sidewalk replacement	2008	4,805	320	15	320		3,362	27
28	Dining Room Doors	2008	8,397	560	15	560		5,879	28
29	Ceiling work	2008	4,374	292	15	292		3,063	29
30				-		-			30
31				-		-			31
32				-		-			32
33				-		-			33
34	TOTAL (lines 1 thru 33)		$ 1,738,866	$ 19,622		$ 22,812	$ 3,190	$ 1,677,561	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: 1/1/18 Ending: 12/31/18

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		$ 1,738,866	$ 19,622		$ 22,812	$ 3,190	$ 1,677,561	1
2	Ceiling Work - North/Center Hall	2009	25,166	1,678	15	1,678		15,939	2
3	A/C West Hall	2009	87,956	5,864	15	5,864		55,706	3
4	Built in Cabinets	2009	4,852	323	15	323		3,071	4
5	A/C Dining Room	2009	8,500	567	15	567		5,384	5
6	Fire Alarm	2009	2,607	174	15	174		1,652	6
7	Sprinkler	2009	5,260	351	15	351		3,332	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		45,066	10
11	A/C Project - North Hall	2010	51,265	3,418	15	3,418		29,051	11
12	Sprinkler System	2010	42,195	2,813	15	2,813		23,911	12
13	Updating - Center Hall	2010	55,277	3,685	15	3,685		31,323	13
14	A/C Project - Downstairs	2010	66,718	4,448	15	4,448		37,807	14
15	South Hall A/C	2010	31,149	2,077	15	2,077		17,652	15
16	Final - Sprinkler System	2010	7,060	471	15	471		4,002	16
17	Updating - Center Hall	2010	38,562	2,571	15	2,571		21,852	17
18	Updating - Downstairs	2010	21,568	1,438	15	1,438		12,222	18
19	Updating - North Hall	2010	15,151	1,010	15	1,010		8,585	19
20	Updating - South Hall	2010	26,058	1,737	15	1,737		14,765	20
21	Transfer from CIP	2010	84,287	5,619	15	5,619		47,762	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	$ 63,168		$ 66,358	$ 3,190	$ 2,061,631	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: 1/1/18 Ending: 12/31/18

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	$ 63,168		$ 66,358	$ 3,190	$ 2,061,631	1
2	Lower level A/C Installation	2011	61,000	4,067	15	4,067		30,501	2
3	South hall A/C work Installation	2011	33,464	2,231	15	2,231		16,732	3
4	Updated-South hall eletrical and Plumbing	2011	60,338	4,023	20	4,023		30,170	4
5	Updated-North hall bathroom-flooring,paint and electrical	2011	9,626	642	20	642		4,814	5
6	Updated-Landscaping	2011	13,853	924	10	924		6,928	6
7	Updated West hall-Bathroom and water softner	2011	4,043	270	20	270		2,023	7
8	Downstairs bathrooms-Flooring,plumbing	2011	11,187	746	20	746		5,594	8
9	Addition to Sprinkler- south hall	2011	8,135	542	20	542		4,066	9
10	Heating equipment Installation on lower level	2011	21,929	1,462	20	1,462		10,965	10
11	North hall flooring	2011	11,519	768	20	768		5,760	11
12	Updated Outside leasehold courtyard- benches,garden	2011	12,571	838	10	838		6,285	12
13	Updated and replaced Roof & gutters	2011	80,797	5,386	10	5,386		40,397	13
14	Updated South hall bathroom-Flooring,door,windows	2011	16,442	1,096	20	1,096		8,221	14
15	Dialysis project retrofit room	2011	25,000	1,667	15	1,667		12,501	15
16	Ozone unit for washing machines	2011	17,000	1,133	10	1,133		8,499	16
17	Water softener	2011	10,939	729	20	729		5,469	17
18	Water heater system installed including plumbing and piping	2011	41,466	2,764	15	2,764		20,732	18
19				-		-			19
20	Labor & Repair to Heating Units	2012	4,875	325	15	325		2,112	20
21	North & Center Hall:Labor, paint, flooring, wallpaper, etc.	2012	26,712	1,781	15	1,781		11,576	21
22	Dialysis Unit Remodel: Labor, flooring, paint, electrical, etc.	2012	168,368	11,225	15	11,225		72,961	22
23	West Hall: Plumbing, bathroom fixtures, electrical,	2012	49,521	3,301	15	3,301		21,458	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		6,996	26
27	Updated West Hall: ceiling, flooring, electric, paint & labor	2013	45,448	2,272	15	2,272		12,497	27
28	West Hall - Project	2013	20,208	1,010	15	1,010		5,556	28
29	South Shower Rooms Update:Labor,tile,grab bars,plumbing	2013	13,289	664	15	664		3,653	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		4,004	31
32	West Hall Improvements: ceiling, bathrooms, electric, paint,	2013	8,182	1,169	15	1,169		6,429	32
33	wallpaper, wood, trim, handrails, baseboards, etc.			-		-			33
34	TOTAL (lines 1 thru 33)		$ 3,212,920	$ 116,203		$ 119,393	$ 3,190	$ 2,428,530	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: 1/1/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,212,920	$ 116,203		$ 119,393	$ 3,190	$ 2,428,530	1
2	Updated Center Hall	2014	16,330	1,089	15	1,089		4,900	2
3	- electric, paper, paint, misc			-		-			3
4	- flooring			-		-			4
5	Updated general heating	2014	31,193	2,080	15	2,080		9,359	5
6	- Equipment (units for heating)			-		-			6
7	- Misc (supplies)			-		-			7
8	Updated general upstairs	2014	33,945	2,263	15	2,263		10,184	8
9	- electric, paper, paint, misc			-		-			9
10	- flooring			-		-			10
11	Updated outside of building	2014	9,217	614	15	614		2,764	11
12	- court yard and entrance			-		-			12
13	Roof repair	2014	14,770	1,477	10	1,477		6,647	13
14				-		-			14
15	Roof - North Hall	2015	19,636	1,964	10	1,964		6,874	15
16	Updated Lower Level, Resident Dining Room	2015	32,842	2,189	15	2,189		7,662	16
17	- electric, paper, paint, misc			-		-			17
18	- flooring			-		-			18
19	Updated General upstairs, Main Lounge	2015	7,747	516	15	516		1,806	19
20	- electric, paper, paint, misc			-		-			20
21				-		-			21
22	Lounge - A/C Outside Unit	2018	16,093	-	15	536	536	536	22
23				-					23
24	Disallowed portion due to outpatient therapy			-		(6,359)	(6,359)		24
25				-		-			25
26				-		-			26
27				-		-			27
28				-		-			28
29				-		-			29
30				-		-			30
31				-		-			31
32				-		-			32
33	To reconcile to financial statements			(11,715)		-	11,715		33
34	TOTAL (lines 1 thru 33)		$ 3,394,693	$ 116,680		$ 125,762	$ 9,082	$ 2,479,262	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: 1/1/18 Ending: 12/31/18

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	$ 716,677	$ 45,992	$ 47,358	$ 1,366	5-10	$ 639,093	71
72	Current Year Purchases	18,149	963	963	-	5-10	963	72
73	Fully Depreciated Assets				-			73
74					-			74
75	TOTALS	$ 734,826	$ 46,955	$ 48,321	$ 1,366		$ 640,056	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	Resident Van	1991 Chevy Lumina	1991	$ 18,008	$ -	$ -	$ -	5	$ 18,008	76
77							-			77
78	See Schedule 13A	Various	Various	190,521	7,895	7,895	-	5	163,762	78
79					-	-	-			79
80	TOTALS			$ 208,529	$ 7,895	$ 7,895	$		$ 181,770	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)	$	4,341,096	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	171,530	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	181,979	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	10,449	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	3,301,088	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, Inc.**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/18**

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	-	-	-	5	5,368
Administrative	Dodge Van	2011	29,688			-	5	29,688
Administrative	Ford Focus	2011	28,877			-	5	28,877
Maintenance	Dodge Truck	2011	39,797			-	5	39,797
Maintenance	Snow Plow & Salt Spreader	2011	5,525			-	5	5,525
Maintenance	Kubuta Mower	2012	13,476			-	5	13,476
Maintenance	M&W Industrial - Forklift	2012	7,495			-	5	7,495
Maintenance	Trailer	2013	10,608	1,059	1,059	-	5	10,608
Facility	Sunset van	2017	34,181	6,836	6,836	-	5	7,422
TOTAL			**190,521**	**7,895**	**7,895**	**-**		**163,762**

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 4752 Description: Copy machine
(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: 1/1/18 Ending: 12/31/18

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

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	40

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)		30,040		30,040
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests			6,759		6,759
9	TOTALS		$	$ 36,799	$	$ 36,799
10	SUM OF line 9, col. 1 and 2	(e)	$ 36,799			

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	20
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	23

(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.

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	39(3)	hrs	$	878	$ 63,197	$	878	$ 63,197	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		513	36,965		513	36,965	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2)(3)	hrs		1,727	124,314	1,446	1,727	125,760	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				84,914		84,914	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Sch 16A	39(2)					30,770		30,770	12
13	Other (specify):									13
14	TOTAL			$	3,118	$ 224,476	$ 117,130	3,118	$ 341,606	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, Inc.**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/18**

Schedule 16A

XIV. Special Services (Direct Cost)
Line 12 Other (specify)

Description	Units	Amount
MEDICAL:In - House Expenses:Oxygen		22,809.00
MEDICAL:VA:Doctor visits		4,532.00
MEDICAL:Private:Medications		2,890.00
THERAPY:Equipment Purchases		110.00
MEDICAL:Medicaid / IPAC:Non Covered Meds		429.00
Total - Line 12		**30,770**

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 29,880	$ 31,821	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,369,605	1,369,605	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,373	20,373	6
7	Other Prepaid Expenses	4,630	4,630	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	24,251	24,251	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,448,739	$ 1,450,680	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,048	13
14	Buildings, at Historical Cost		646,817	14
15	Leasehold Improvements, at Historical Cost	2,518,296	2,747,876	15
16	Equipment, at Historical Cost	821,913	943,355	16
17	Accumulated Depreciation (book methods)	(2,332,120)	(3,301,088)	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)**	$ 1,008,089	$ 1,040,008	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,456,828	$ 2,490,688	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 216,164	$ 216,164	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,029	1,029	28
29	Short-Term Notes Payable	22,079	22,079	29
30	Accrued Salaries Payable	1,313	1,313	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,498	22,498	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
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 325,083	$ 325,083	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,926,660	1,926,660	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Stockholders loan		500	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,926,660	$ 1,927,160	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,251,743	$ 2,252,243	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 205,085	$ 238,445	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,456,828	$ 2,490,688	48

***(See instructions.)**

Facility Name: **Medina Nursing Center, Inc.**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/18**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
Employee Advances	(457.00)	(457.00)
Due From Accounts:Note Due From Cna First	24,708.00	24,708.00
Total - Line 9	**24,251**	**24,251**

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 431,096	1
2	Restatements (describe):		2
3	**Prior period adjustment**	(86,852)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 344,244	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(139,159)	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)**	$ (139,159)	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)**	$ 205,085	24 *

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

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,621,796	1
2	Discounts and Allowances for all Levels	(2,706,946)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,914,850	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,487,527	6
7	Oxygen	71,616	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,559,143	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	8	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,725	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	121,536	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,361	19
20	Radiology and X-Ray	2,403	20
21	Other Medical Services	212,578	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 342,611	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,573	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,573	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	71,939	28
28a	See Schedule 19A	30,409	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 102,348	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,935,525	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,041,723	31
32	Health Care	1,957,348	32
33	General Administration	963,480	33
	B. Capital Expense		
34	Ownership	335,129	34
	C. Ancillary Expense		
35	Special Cost Centers	562,891	35
36	Provider Participation Fee	214,113	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,074,684	40
41	**Income before Income Taxes (line 30 minus line 40)****	(139,159)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (139,159)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ (340,480)	44
45	Private Pay - Net Inpatient Revenue	2,917,779	45
46	Medicare - Net Inpatient Revenue	(209,890)	46
47	Other-(specify) Hospice	256,097	47
48	Other-(specify) See Schedule 19C	291,344	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,914,850	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, Inc.**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/18**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

	Description	Amount
30010-00-0000	Private:30010 · Equipment Rental	5,739
31010-00-0000	Medicaid / Ipac:31010 · Equipment Rental	33,261
32010-00-0000	Medicare A:32010 · Equipment Rental	3,477
34010-00-0000	Hmo / Managed Care:34010 · Equipment Rental	315
35010-00-0000	Hospice:35010 · Equipment Rental	21,796
36010-00-0000	Va:36010 · Equipment Rental	7,351
	Total - Line 28	**71,939**

XVII. Income Statement
Line 28a Other Expenses (specify):

	Description	Amount
30013-00-0000	Private:30013 · Miscellaneous	8,224
34013-00-0000	Hmo / Managed Care:34013 · Miscellaneous	1
35055-00-0000	Hospice:35055 · Refunds	3,870
36013-00-0000	Va:36013 · Misc	69
38005-00-0000	Misc Sales:Apartment Sales:Meals	3,000
38006-00-0000	Misc Sales:Apartment Sales:Misc.	5,545
38007-00-0000	Misc Sales:Apartment Sales:Salon	2,400
38008-00-0000	Misc Sales:Refund/Rebates/Settelments	7,300
	Total - Line 28a	**30,409**

Facility Name: **Medina Nursing Center, Inc.**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/18**

Schedule 19C

XVII. Income Statement
Line 48 Net Inpatient Revenue detailed by Payer Source Other (specify):

Description	Amount
Contractual Allowance - Outpatient	(280,826)
Veterans Assistance	572,170
Total - Line 48	**291,344**

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

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	1,996	2,116	$ 80,378	$ 37.99	1
2	Assistant Director of Nursing	1,944	2,133	44,644	20.93	2
3	Registered Nurses	14,091	15,290	417,753	27.32	3
4	Licensed Practical Nurses	4,232	4,682	124,044	26.49	4
5	CNAs & Orderlies	51,048	53,367	714,753	13.39	5
6	CNA Trainees	1,169	1,169	30,040	25.70	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,823	1,859	22,592	12.15	9
10	Activity Assistants	4,063	4,283	40,222	9.39	10
11	Social Service Workers	4,162	4,286	75,578	17.63	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	46,864	22.53	13
14	Head Cook	3,305	3,509	75,899	21.63	14
15	Cook Helpers/Assistants	14,257	15,195	158,833	10.45	15
16	Dishwashers					16
17	Maintenance Workers	6,392	6,826	86,571	12.68	17
18	Housekeepers	8,809	9,518	107,615	11.31	18
19	Laundry	3,261	3,397	39,901	11.75	19
20	Administrator	1,960	2,080	137,800	66.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,553	5,845	103,928	17.78	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	1,979	2,139	29,002	13.56	31
32	Other Health Care(specify)					32
33	Other(specify) Admissions	1,960	2,080	47,680	22.92	33
34	TOTAL (lines 1 - 33)	133,961	141,854	$ 2,384,097 *	$ 16.81	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	Monthly	$ 5,769	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	3,642	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	1,229	11(3)	44
45	Social Service Consultant	20	1,536	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	36	$ 27,776		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	185	$ 7,674	10(3)	50
51	Licensed Practical Nurses	1,614	63,847	10(3)	51
52	Certified Nurse Assistants/Aides	5,164	159,918	10(3)	52
53	TOTAL (lines 50 - 52)	6,962	$ 231,439		53

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Holgeir Oksnevad	Administrator	100	$ 137,800
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 137,800

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 Sch21C		$ 74,840
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 74,840

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,276
Unemployment Compensation Insurance	14,065
FICA Taxes	175,867
Employee Health Insurance	151,512
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	53,087
Employee Relations	3,955
Employee Physicals	5,139
Wellness/Fitness	685
TOTAL (agree to Schedule V, line 22, col.8)	$ 491,586

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	591
Health Care Worker Background Check	
(Indicate # of checks performed 2)	29
Patient Background Checks 66	1,056
Misc. Licenses & Fees	519
Misc Dues & Subscriptions	1,330
IL Secretary of State License	831
Dues-certificate & fees	547
IHCA	5,974
Less: Public Relations Expense	(1,904)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,953

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,741
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,741

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Medina Nursing Center, Inc.**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/18**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	27,515
Reno & Zahm LLP	Legal	504
Duane Morris LLP	Legal	16,291
Ability Network Inc.	Computer Services	6,147
Point Click Care	Computer Services	20,197
Gordon Food Service	Computer Services	540
Microsoft Store	Computer Services	74
Net@work, Inc	Computer Services	3,372
Isolved Hcm	Computer Services	200
	Total (agree to Schedule V, line 19, column 3)	74,840
Less: Non-Allowable Legal Fees		(8,896)
	Total (agree to Schedule V, line 19, column 8)	65,944

Facility Name & ID Number Medina Nursing Center, Inc. # 0011551 Report Period Beginning: 1/1/18 Ending: 12/31/18

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 - $5,974**

(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? **N/A**

(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? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,565** 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. $ **214,113**
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? **Yes** Indicate the amount. $ **2,725**

(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 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.