		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0011551

Facility Name: Medina Nursing Center

Address: 402 South Center St (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
  - [ ] Charitable Corp.
  - [ ] Trust
- IRS Exemption Code

- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [X] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other

- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 1/1/2020 to 12/31/2020 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 # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	89	Skilled (SNF)	89	32,574	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	32,574	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	361	152	862	1,375	8
9	SNF/PED					9
10	ICF	15,209	3,154	3,081	21,444	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,570	3,306	3,943	22,819	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.05%

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 862

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: 12/31/2020 Fiscal Year: 12/31/2020

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

STATE OF ILLINOIS

Facility Name & ID Number Medina Nursing Center # 0011551 **Report Period Beginning:** 1/1/2020 **Ending:** 12/31/2020

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	318,168	43,173	5,473	366,814		366,814		366,814			1
2	Food Purchase		234,094		234,094		234,094	(395)	233,699			2
3	Housekeeping	122,229	55,138	-	177,367		177,367		177,367			3
4	Laundry	45,575	10,398	-	55,973		55,973		55,973			4
5	Heat and Other Utilities			97,351	97,351		97,351		97,351			5
6	Maintenance	146,630	21,601	79,154	247,385		247,385		247,385			6
7	Other (specify):*	-	-	-								7
8	**TOTAL General Services**	632,602	364,404	181,978	1,178,984		1,178,984	(395)	1,178,589			8
	B. Health Care and Programs											
9	Medical Director	-	-	14,500	14,500		14,500		14,500			9
10	Nursing and Medical Records	1,643,222	200,657	162,890	2,006,769		2,006,769		2,006,769			10
10a	Therapy	-	-	-								10a
11	Activities	74,736	945	9,074	84,755		84,755		84,755			11
12	Social Services	82,522	-	2,213	84,735		84,735		84,735			12
13	CNA Training	10,784	47	198	11,029		11,029		11,029			13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	**TOTAL Health Care and Programs**	1,811,264	201,649	188,875	2,201,788		2,201,788		2,201,788			16
	C. General Administration											
17	Administrative	222,618	-	-	222,618		222,618		222,618			17
18	Directors Fees			-								18
19	Professional Services			89,915	89,915		89,915	(29)	89,886			19
20	Dues, Fees, Subscriptions & Promotions			24,053	24,053		24,053	(2,005)	22,048			20
21	Clerical & General Office Expenses	124,591	9,644	116,230	250,465		250,465	(7,872)	242,593			21
22	Employee Benefits & Payroll Taxes			493,965	493,965		493,965		493,965			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			1,916	1,916		1,916		1,916			24
25	Other Admin. Staff Transportation		-	6,559	6,559		6,559		6,559			25
26	Insurance-Prop.Liab.Malpractice			83,864	83,864		83,864		83,864			26
27	Other (specify):*			-								27
28	**TOTAL General Administration**	347,209	9,644	816,502	1,173,355		1,173,355	(9,906)	1,163,449			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,791,075	575,697	1,187,355	4,554,127		4,554,127	(10,301)	4,543,826			29

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

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

Facility Name & ID Number: Medina Nursing Center #0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			212,307	212,307		212,307	1,124	213,431			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			84,979	84,979		84,979	(12,750)	72,229			32
33	Real Estate Taxes			54,642	54,642		54,642		54,642			33
34	Rent-Facility & Grounds			14,750	14,750		14,750	(14,750)				34
35	Rent-Equipment & Vehicles			9,811	9,811		9,811		9,811			35
36	Other (specify):*			-								36
37	**TOTAL Ownership**			376,489	376,489		376,489	(26,376)	350,113			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	86,654	226,099	312,753		312,753	(57,420)	255,333			39
40	Barber and Beauty Shops	-	-	2,293	2,293		2,293		2,293			40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			184,096	184,096		184,096		184,096			42
43	Other (specify):* Non-Allowable Cos	55,885	-	33,866	89,751		89,751	(89,751)				43
44	**TOTAL Special Cost Centers**	55,885	86,654	446,354	588,893		588,893	(147,171)	441,722			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,846,960	662,351	2,010,198	5,519,509		5,519,509	(183,848)	5,335,661			45

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(395)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,049)	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	(2,122)	30		9
10	Interest and Other Investment Income	(12,750)	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	(1,636)	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	(1,244)	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	(151,148)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (172,344)		$	30

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

		1 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)	(11,504)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (11,504)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (183,848)		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

BHF USE ONLY

48		49		50		51		52	

Medina Nursing Center

ID# 0011551

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs	$ (18,265)	43	1
2	X-Rays	(3,205)	43	2
3	Goodwill	(3,310)	43	3
4	Federal Income Tax	(3,157)	43	4
5	Admissions	(55,885)	43	5
6	Therapy	(57,420)	39	6
7	Lobby Expense	(2,005)	20	7
8	Nonallowable Legal	(29)	19	8
9	Misc Revenue Offset	(7,872)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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**	(151,148)		49

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	Durand	Lessor
				Building, Inc.		

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.		$ 3,246	$ 3,246	1
2	V	34	Building Rent	14,750	Medina Manor Building, Inc.			(14,750)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 14,750			$ 3,246	$ * (11,504)	14

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Holgeir Oksnevad	President	Administrator	100	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 # 0011551 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	11/30/2016	$ 1,097,980	$ 884,716	11/30/2021	0.0595	$ 46,532	1
2	Durand State Bank		X	Van	658.22	11/16/2017	35,175	13,045	11/16/2022	0.0459	717	2
3	BMW Bank of North America		X	Vehicle	1,267.82	3/14/2019	68,921	39,238	3/14/2024	0.0389	1,940	3
4	Subaru Motors Finance		X	Vehicle	750.53	4/20/2019	33,578	8,225	4/20/2024	0.0349	869	4
5	Durand State Bank		X	Therapy Building	1,815.55	7/31/2019	250,000	238,087	7/31/2024	0.0613	12,182	5
	Working Capital											
6	Davis Bank		X	Working Capital	None	6/27/2012	400,000	-	1/30/2020	0.05	7,934	6
7	Durand Bank		X	Working Capital	None	8/14/2012	650,000	(40)	11/30/2020	0.05375	9,705	7
8	H. Oksnevad	X		Working Capital	None	Varies	Varies		Demand	None	4,585	8
9	TOTAL Facility Related				$13,714.12		$ 2,535,654	$ 1,183,271			$ 84,464	9
	B. Non-Facility Related*											
10								Disallowed Interest and fina			(12,695)	10
11								Offset interest income			(54)	11
12								Finance Charges			514	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (12,235)	14
15	TOTALS (line 9+line14)						$ 2,535,654	$ 1,183,271			$ 72,229	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 # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Description		Amount	Line
1. Real Estate Tax accrual used on 2019 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.)	2019	$ 54,642	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,358)	3
4. Real Estate Tax accrual used for 2020 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.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 54,642	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015	59,482	8
2016	60,371	9
2017	56,954	10
2018	57,311	11
2019	54,642	12

2019 RE Taxes $54,642
54,642*113.47%= 62,002
Will use $62,000

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 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 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	05-15-251-003	Medina Manor Building	$ 1,188.74	$ 1,188.74
2.	05-15-251-008	Medina Manor Building	$ 1,163.20	$ 1,163.20
3.	05-15-251-011	Medina Manor Building	$ 52,289.90	$ 52,289.90
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,641.84	$ 54,641.84

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [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 # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			3,246	3,246		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		20			51,619	28
29	Building Improvements			1991	11,626		20			11,626	29
30	Building Improvements			1992	39,070		20			39,070	30
31	Building Improvements			1992	3,295		20			3,295	31
32	Building Improvements			1992	19,372		20			19,372	32
33	Building Improvements			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 # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$		$ 3,246	$ 3,246	$ 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 # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$		$ 3,246	$ 3,246	$ 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		15			11,656	19
20	Roof	2003	7,470		15			7,470	20
21	Alarm Installation	2003	12,730		15			12,730	21
22	Cabinets	2004	504		15			494	22
23	Surveillance Cameras	2004	578		15			578	23
24	Time Clock	2004	10,000		15			10,000	24
25	Latches	2004	8,923		15			8,923	25
26	Exhaust Hood	2004	4,290	71	15	71		4,290	26
27	Bath Call Light	2004	1,229	14	15	14		1,229	27
28	Ventilator	2004	1,038	19	15	19		1,038	28
29	Driveway	2004	4,000	22	15	22		4,000	29
30	Sidewalk & Driveway	2005	5,209	175	15	175		5,209	30
31	Wiring & Outlets	2005	8,903	295	15	295		8,903	31
32	Windows	2005	1,911	65	15	65		1,911	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,507,007	$ 661		$ 3,907	$ 3,246	$ 1,506,997	34

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 661		$ 3,907	$ 3,246	$ 1,506,997	1
2	Flag Poles	2005	4,362	291	15	145	(146)	4,362	2
3								-	3
4	Fire Alarm System	2006	12,455	830	15	830		12,038	4
5	Doors and Gaskets	2006	6,545	436	15	436		6,325	5
6	Water Softner	2006	965	64	15	64		931	6
7	Landscaping Improvements	2006	2,377	158	15	158		2,296	7
8	Timeclock	2006	20,715	1,381	15	1,381		20,025	8
9	Roofing	2006	1,350	90	15	90		1,305	9
10	Fire Door	2006	965	64	15	64		931	10
11	Hot Water Storage Tank	2006	11,998	800	15	800		11,599	11
12	A/C Compressor	2006	1,777	118	15	118		1,715	12
13	Fire Alarm Panel	2006	3,200	213	15	213		3,092	13
14								-	14
15	Roofing	2007	2,675	178	15	178		2,406	15
16	Fire Safety Doors	2007	3,111	207	15	207		2,798	16
17	Kitchen Cabinets	2007	4,131	275	15	275		3,716	17
18	Water Treatment System	2007	11,465	764	15	764		10,317	18
19	Timeclock system	2007	4,034	269	15	269		3,631	19
20								-	20
21	Sprinkler	2008	33,686	2,246	15	2,246		28,073	21
22	Tub room improvements	2008	20,275	1,352	15	1,352		16,898	22
23	Generator	2008	44,840	2,989	15	2,989		37,365	23
24	Wiring	2008	12,182	812	15	812		10,151	24
25	Pipe Insulation	2008	6,807	454	15	454		5,674	25
26	Fire Stops	2008	4,368	291	15	291		3,639	26
27	Sidewalk replacement	2008	4,805	320	15	320		4,002	27
28	Dining Room Doors	2008	8,397	560	15	560		6,999	28
29	Ceiling work	2008	4,374	292	15	292		3,647	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,738,866	$ 16,115		$ 19,215	$ 3,100	$ 1,710,932	34

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 16,115		$ 19,215	$ 3,100	$ 1,710,932	1
2	Ceiling Work - North/Center Hall	2009	25,166	1,678	15	1,678		19,295	2
3	A/C West Hall	2009	87,956	5,864	15	5,864		67,434	3
4	Built in Cabinets	2009	4,852	323	15	323		3,717	4
5	A/C Dining Room	2009	8,500	567	15	567		6,518	5
6	Fire Alarm	2009	2,607	174	15	174		2,000	6
7	Sprinkler	2009	5,260	351	15	351		4,034	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		55,670	10
11	A/C Project - North Hall	2010	51,265	3,418	15	3,418		35,887	11
12	Sprinkler System	2010	42,195	2,813	15	2,813		29,537	12
13	Updating - Center Hall	2010	55,277	3,685	15	3,685		38,693	13
14	A/C Project - Downstairs	2010	66,718	4,448	15	4,448		46,703	14
15	South Hall A/C	2010	31,149	2,077	15	2,077		21,806	15
16	Final - Sprinkler System	2010	7,060	471	15	471		4,944	16
17	Updating - Center Hall	2010	38,562	2,571	15	2,571		26,994	17
18	Updating - Downstairs	2010	21,568	1,438	15	1,438		15,098	18
19	Updating - North Hall	2010	15,151	1,010	15	1,010		10,605	19
20	Updating - South Hall	2010	26,058	1,737	15	1,737		18,239	20
21	Transfer from CIP	2010	84,287	5,619	15	5,619		59,000	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	$ 59,661		$ 62,761	$ 3,100	$ 2,182,094	34

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,397,012	$ 59,661		$ 62,761	$ 3,100	$ 2,182,094	1
2	Lower level A/C Installation	2011	61,000	4,067	15	4,067		38,635	2
3	South hall A/C work Installation	2011	33,464	2,231	15	2,231		21,194	3
4	Updated-South hall eletrical and Plumbing	2011	60,338	4,023	20	4,023		38,216	4
5	Updated-North hall bathroom-flooring,paint and electrical	2011	9,626	642	20	642		6,098	5
6	Updated-Landscaping	2011	13,853	924	10	924		8,776	6
7	Updated West hall-Bathroom and water softner	2011	4,043	270	20	270		2,563	7
8	Downstairs bathrooms-Flooring,plumbing	2011	11,187	746	20	746		7,086	8
9	Addition to Sprinkler- south hall	2011	8,135	542	20	542		5,150	9
10	Heating equipment Installation on lower level	2011	21,929	1,462	20	1,462		13,889	10
11	North hall flooring	2011	11,519	768	20	768		7,296	11
12	Updated Outside leasehold courtyard- benches,garden	2011	12,571	838	10	838		7,961	12
13	Updated and replaced Roof & gutters	2011	80,797	5,386	10	5,386		51,169	13
14	Updated South hall bathroom-Flooring,door,windows	2011	16,442	1,096	20	1,096		10,413	14
15	Dialysis project retrofit room	2011	25,000	1,667	15	1,667		15,835	15
16	Ozone unit for washing machines	2011	17,000	1,133	10	1,133		10,765	16
17	Water softener	2011	10,939	729	20	729		6,927	17
18	Water heater system installed including plumbing and piping	2011	41,466	2,764	15	2,764		26,260	18
19								-	19
20	Labor & Repair to Heating Units	2012	4,875	325	15	325		2,762	20
21	North & Center Hall:Labor, paint, flooring, wallpaper, etc.	2012	26,712	1,781	15	1,781		15,138	21
22	Dialysis Unit Remodel: Labor, flooring, paint, electrical, etc.	2012	168,368	11,225	15	11,225		95,411	22
23	West Hall: Plumbing, bathroom fixtures, electrical,	2012	49,521	3,301	15	3,301		28,060	23
24	paint, flooring, labor, etc.							-	24
25								-	25
26	Dialysis Unit: IDPH & consulting fees, smoke detectors, blinds	2013	25,438	1,696	15	1,696		10,388	26
27	Updated West Hall: ceiling, flooring, electric, paint & labor	2013	45,448	3,032	15	3,032		18,561	27
28	West Hall - Project	2013	20,208	1,345	15	1,345		8,246	28
29	South Shower Rooms Update:Labor,tile,grab bars,plumbing	2013	13,289	886	15	886		5,425	29
30	slate tile, grout, shower base, faucets, etc.							-	30
31	Center Hall: Carpet, electrical, paint, pictures, labor, etc.	2013	14,558	971	15	971		5,946	31
32	West Hall Improvements: ceiling, bathrooms, electric, paint,	2013	8,182	545	15	545		7,519	32
33	wallpaper, wood, trim, handrails, baseboards, etc.								33
34	TOTAL (lines 1 thru 33)		$ 3,212,920	$ 114,056		$ 117,156	$ 3,100	$ 2,657,783	34

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 114,056		$ 117,156	$ 3,100	$ 2,657,783	1
2	Updated Center Hall	2014	16,330	1,089	15	1,089		7,078	2
3	- electric, paper, paint, misc							-	3
4	- flooring							-	4
5	Updated general heating	2014	31,193	2,080	15	2,080		13,519	5
6	- Equipment (units for heating)							-	6
7	- Misc (supplies)							-	7
8	Updated general upstairs	2014	33,945	2,263	15	2,263		14,710	8
9	- electric, paper, paint, misc							-	9
10	- flooring							-	10
11	Updated outside of building	2014	9,217	614	15	614		3,992	11
12	- court yard and entrance							-	12
13	Roof repair	2014	14,770	985	10	985		8,617	13
14								-	14
15	Roof - North Hall	2015	19,636	1,309	10	1,309		9,492	15
16	Updated Lower Level, Resident Dining Room	2015	32,842	2,189	15	2,189		12,040	16
17	- electric, paper, paint, misc							-	17
18	- flooring							-	18
19	Updated General upstairs, Main Lounge	2015	7,747	516	15	516		2,838	19
20	- electric, paper, paint, misc							-	20
21								-	21
22	Lounge - A/C Outside Unit	2018	16,093		15	1,073	1,073	2,682	22
23								-	23
24	Furnish & Install TPO Membrane Roof System - Roof (North hall)	2019	70,800	4,720	15	4,720		7,473	24
25	R/M: Furnish & Install 8 ton A/C Unit - West Wing (Lounge)	2019	17,939		15	1,198	1,198	1,794	25
26	Disallowed portion due to outpatient therapy					(2,887)	(2,887)		26
27	A/C unit for Center Hall	2020	19,262	1,926	15	642	(1,284)	642	27
28	A/C unit lower level	2020	11,965	1,197	15	399	(798)	399	28
29	Upgrade Fire Alarm in Main Facility	2020	21,414	714	15	714	(0)	714	29
30								-	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,536,073	$ 133,658		$ 134,060	$ 402	$ 2,743,773	34

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 12F, Carried Forward		$ 3,536,073	$ 133,658		$ 134,060	$ 402	$ 2,743,773	1
2	Therapy building improvement								2
3	Demo & Construction	2020	52,744	2,051	15	2,051		2,051	3
4	Ceiling, paint, misc	2020	27,636	1,075	15	1,075		1,075	4
5	Electrical	2020	23,885	929	15	929		929	5
6	Plumbing, flooring, entrance	2020	23,044	896	15	896		896	6
7									7
8									8
9									9
10									10
11									11
12	To reconcile to financial statements			(722)			722		12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,663,381	$ 137,887		$ 139,011	$ 1,124	$ 2,748,724	34

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 626,375	$ 20,122	$ 20,122	$	5-10	$ 557,920	71
72	Current Year Purchases	57,752	6,116	6,116		5	6,116	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 684,127	$ 26,238	$ 26,238	$		$ 564,036	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				$	$ -	$ -	$		$	76
77					-	-				77
78	See Schedule 13A	Various	Various	389,486	48,182	48,182		5	234,766	78
79					-	-				79
80	TOTALS			$ 389,486	$ 48,182	$ 48,182	$		$ 234,766	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)	$ 4,740,042	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,307	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 213,431	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,124	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,547,526	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name: Medina Nursing Center
IDPH License ID Number: 0011551
Fiscal Year End: 12/31/2020

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	Dodge Truck	2011	39,797	-	-	-	5	39,797
Administrative	Dodge Van	2011	29,688	-	-	-	5	29,688
Maintenance	Jeep Wrangler Rubicon	2019	101,231	20,246	20,246	-	5	28,683
Administrative	Kubota RTV	2013	27,729	-	-	924	5	26,805
Administrative	BMW X4	2019	68,921	13,784	13,784	-	5	25,271
Facility	Sunset van	2017	34,181	6,836	6,836	-	5	21,094
Administrative	2006 Ford Bus	2009	15,506	-	-	-	5	15,506
Maintenance	Kubuta Mower	2012	13,476	-	-	-	5	13,476
Administrative	Subaru Forestar	2019	36,579	7,316	7,316	-	5	12,193
Maintenance	M&W Industrial - Forklift	2012	7,495	-	-	125	5	7,370
Maintenance	Snow Plow & Salt Spreader	2011	5,525	-	-	-	5	5,525
Maintenance	Trailer	2010	5,358	-	-	-	5	5,358
Maintenance	Snowplow for dodge truck	2009	4,000	-	-	-	5	4,000
Total			**389,486**	**48,182**	**48,182**	**1,049**		**234,766**

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 9,811 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 # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		10,784		10,784
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests		245		245
9	TOTALS	$	$ 11,029	$	$ 11,029
10	SUM OF line 9, col. 1 and 2 (e)	$ 11,029			

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	4
2. From other facilities (f)	6
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	10

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	866	$ 62,320	$	866	$ 62,320	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		385	27,730		385	27,730	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2)(3)	hrs		1,092	78,629	1,486	1,092	80,115	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				74,974		74,974	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Sch 16A	39(2)					10,194		10,194	12
13	Other (specify):									13
14	TOTAL			$	2,343	$ 168,679	$ 86,654	2,343	$ 255,333	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name: **Medina Nursing Center**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/2020**

Schedule 16A

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

Description	Amount
MEDICAL:In - House Expenses:Oxygen	9,025
MEDICAL: Medicare A	373
MEDICAL:Medicaid / IPAC:Non Covered Meds	796
Total - Line 12	**10,194**

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 1,152,675	$ 1,154,096	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (237,225))	263,068	263,068	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	24,030	24,030	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,464,776	$ 1,466,197	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	2,812,444	3,016,564	15
16	Equipment, at Historical Cost	1,073,613	1,073,613	16
17	Accumulated Depreciation (book methods)	(2,683,214)	(3,547,526)	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 (spe	-	-	22
23	Other(specify):	-	-	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,202,843	$ 1,192,516	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,667,619	$ 2,658,713	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 142,472	$ 142,472	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	13,802	13,802	30
31	Accrued Taxes Payable (excluding real estate taxes)	(11,518)	(11,518)	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	See Sch 17A	140,931	140,931	36
37		-	-	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 347,687	$ 347,687	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,183,271	1,183,271	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)**	$ 1,183,271	$ 1,183,771	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,530,958	$ 1,531,458	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,136,661	$ 1,127,255	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,667,619	$ 2,658,713	48

*(See instructions.)

Facility Name: **Medina Nursing Center**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/2020**

Schedule 17A

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

Description	Operating	After Consolidation
Employee Advances Account:Employee Advances	(678)	(678)
Due From Accounts:Note Due From Cna First	24,708	24,708
Total - Line 9	**24,030**	**24,030**
	-	-

Line 36 Line of Credit:

Description	Operating	After Consolidation
Line Of Credit - Insurance Damage Payment	140,931	140,931
Total - Line 9	**140,931**	**140,931**
	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (396,921)	1
2	Restatements (describe):		2
3	**Prior period adjustment**	66,143	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (330,778)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,467,439	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)**	$ 1,467,439	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)**	$ 1,136,661	24 *

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 6,592,051	1
2	Discounts and Allowances for all Levels	(2,985,654)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,606,397	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	994,812	6
7	Oxygen	-	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 994,812	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	2,214,846	10
11	CNA Training Reimbursements	28	11
12	Gift and Coffee Shop	-	12
13	Barber and Beauty Care	2,018	13
14	Non-Patient Meals	395	14
15	Telephone, Television and Radio	-	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	104,190	17
18	Sale of Supplies to Non-Patients	-	18
19	Laboratory	13,181	19
20	Radiology and X-Ray	3,100	20
21	Other Medical Services	5,585	21
22	Laundry	-	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,343,343	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	54	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	42,342	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 42,342	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,986,948	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,178,984	31
32	Health Care	2,201,788	32
33	General Administration	1,173,355	33
	B. Capital Expense		
34	Ownership	376,489	34
	C. Ancillary Expense		
35	Special Cost Centers	404,797	35
36	Provider Participation Fee	184,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,519,509	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,467,439	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,467,439	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,264,872	44
45	Private Pay - Net Inpatient Revenue	702,350	45
46	Medicare - Net Inpatient Revenue	(149,078)	46
47	Other-(specify) Hospice	336,410	47
48	Other-(specify) See Schedule 19C	451,843	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,606,397	49

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

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

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

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

^Entity is a cash basis taxpayer.

Facility Name: **Medina Nursing Center**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/2020**

Schedule 19A

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

Description	Amount
Equipment Rental	18,205
Misc Apartment Sales	14,473
Misc Inc	9,664
Total - Line 28	**42,342**
	-

Facility Name: **Medina Nursing Center**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/2020**

Schedule 19C

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

Description	Amount
Contractual Allowance - Outpatient	(106,311)
Contractual Allowance - Therapy	(2,046)
Managed Care	2,803
Veterans Assistance	557,397
Total - Line 48	**451,843**
	-

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,199	2,201	$ 92,769	$ 42.15	1
2	Assistant Director of Nursing	2,050	2,230	58,475	26.22	2
3	Registered Nurses	15,470	16,867	554,773	32.89	3
4	Licensed Practical Nurses	3,811	4,270	114,361	26.78	4
5	CNAs & Orderlies	45,549	47,808	792,813	16.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,831	2,040	29,358	14.39	9
10	Activity Assistants	2,996	3,304	45,378	13.73	10
11	Social Service Workers	3,654	3,763	82,522	21.93	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	52,444	25.21	13
14	Head Cook	5,949	6,383	93,397	14.63	14
15	Cook Helpers/Assistants	13,768	14,690	172,327	11.73	15
16	Dishwashers					16
17	Maintenance Workers	8,242	8,684	146,630	16.89	17
18	Housekeepers	8,932	9,677	122,229	12.63	18
19	Laundry	4,202	4,326	45,575	10.54	19
20	Administrator	3,000	3,120	137,800	44.17	20
21	Assistant Administrator	2,080	2,080	84,818	40.78	21
22	Other Administrative					22
23	Office Manager	6,206	6,408	124,591	19.44	23
24	Clerical					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	1,969	2,161	30,031	13.90	31
32	Other Health Ca CNA Instructor	243	403	10,784	26.76	32
33	Other(specify) Admissions	2,056	2,080	55,885	26.87	33
34	TOTAL (lines 1 - 33)	136,207	144,575	$ 2,846,960 *	$ 19.69	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	104	$ 5,473	1(3)	35
36	Medical Director	48	14,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	3,850	10(3)	38
39	Pharmacist Consultant	12	3,680	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	7	508	11(3)	44
45	Social Service Consultant	28	1,915	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	199	$ 29,926		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	61	$ 11,019	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	3,724	143,741	10(3)	52
53	TOTAL (lines 50 - 52)	3,785	$ 154,760		53

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Holgeir Oksnevad	Administrator	100	$ 137,800
Peggy Lauer	Assistant Administrator	0	84,818
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 222,618

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		$ 89,886
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 89,886

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,468
Unemployment Compensation Insurance	12,629
FICA Taxes	211,207
Employee Health Insurance	167,771
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	55,214
Employee Relations	3,502
Employee Physicals	4,278
Wellness/Fitness	(104)
TOTAL (agree to Schedule V, line 22, col.8)	$ 493,965

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	5,685
Health Care Worker Background Check (Indicate # of checks performed 20)	348
Patient Background Checks 65	1,490
Misc. Dues & Subscriptions	1,787
Misc Licenses & Fees	1,261
IL Secretary of State	1,742
Certification Fees	462
IHCA	7,298
Less: Public Relations Expense	(2,005)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,048

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,916
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,916

**See instructions.

Facility Name: **Medina Nursing Center**
IDPH License ID Number: **0011551**
Fiscal Year End: **12/31/2020**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	28,397
Reno & Zahm Llp	Legal	3,295
Duane Morris	Legal	4,835
PointClickCare Technologies Inc.	Computer Services	23,127
Intuit Quickbooks Pro	Computer Services	3,405
iSolved HCM	Computer Services	2,520
Ability Network Inc.	Computer Services	6,777
Brian W Law	Computer Services	184
Gordon Food Service	Computer Services	540
DRI*Avast Software	Computer Services	138
Smartlinx Solutions LLC	Computer Services	16,095
Net@work, Inc	Computer Services	602
	Total (agree to Schedule V, line 19, column 3)	89,915
Less: Non-Allowable Legal Fees		(29)
	Total (agree to Schedule V, line 19, column 8)	89,886

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 - $7,298**

(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? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,549** 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. $ **184,096**
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. $ **-** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **395**

(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.