

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

Address: 402 South Center St Durand 61024
Number City 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

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "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 01/01/2016 to 12/31/2016 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) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____
(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: 01/01/2016 Ending: 12/31/2016

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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		471	3,201	3,672	8
9	SNF/PED					9
10	ICF	14,239	4,724	1,035	19,998	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,239	5,195	4,236	23,670	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.67%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES 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 NO X Date N/A

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 612

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: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	269,508	20,925	7,532	297,965		297,965		297,965			1
2	Food Purchase		224,197		224,197		224,197	(107)	224,090			2
3	Housekeeping	117,136	42,384		159,520		159,520		159,520			3
4	Laundry	49,783	4,859		54,642		54,642		54,642			4
5	Heat and Other Utilities			89,598	89,598		89,598		89,598			5
6	Maintenance	96,372	31,983	39,927	168,282		168,282		168,282			6
7	Other (specify):*											7
8	TOTAL General Services	532,799	324,348	137,057	994,204		994,204	(107)	994,097			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	1,317,505	134,441	235,366	1,687,312		1,687,312	(3)	1,687,309			10
10a	Therapy											10a
11	Activities	99,693	2,982	15,822	118,497		118,497		118,497			11
12	Social Services	93,520		922	94,442		94,442	(43,600)	50,842			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,510,718	137,423	267,710	1,915,851		1,915,851	(43,603)	1,872,248			16
	C. General Administration											
17	Administrative	137,800			137,800		137,800		137,800			17
18	Directors Fees											18
19	Professional Services			76,983	76,983		76,983	(14,811)	62,172			19
20	Dues, Fees, Subscriptions & Promotions			20,604	20,604		20,604	(2,401)	18,203			20
21	Clerical & General Office Expenses	106,730	14,454	63,935	185,119		185,119		185,119			21
22	Employee Benefits & Payroll Taxes			394,615	394,615		394,615		394,615			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,633	11,633		11,633	(187)	11,446			24
25	Other Admin. Staff Transportation			6,539	6,539		6,539		6,539			25
26	Insurance-Prop.Liab.Malpractice			71,067	71,067		71,067		71,067			26
27	Other (specify):*											27
28	TOTAL General Administration	244,530	14,454	645,376	904,360		904,360	(17,399)	886,961			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,288,047	476,225	1,050,143	3,814,415		3,814,415	(61,109)	3,753,306			29

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

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

Facility Name & ID Number Medina Nursing Center #0011551 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			208,056	208,056		208,056	(14,059)	193,997			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			108,868	108,868		108,868	(365)	108,503			32
33	Real Estate Taxes			60,390	60,390		60,390	(1,235)	59,155			33
34	Rent-Facility & Grounds			8,100	8,100		8,100	(8,100)				34
35	Rent-Equipment & Vehicles			4,831	4,831		4,831		4,831			35
36	Other (specify):*											36
37	TOTAL Ownership			390,245	390,245		390,245	(23,759)	366,486			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		154,297	278,294	432,591		432,591	(93,899)	338,692			39
40	Barber and Beauty Shops			12,191	12,191		12,191		12,191			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			185,754	185,754		185,754		185,754			42
43	Other (specify):* Non-Allowable Cos			44,241	44,241		44,241	(44,241)				43
44	TOTAL Special Cost Centers		154,297	520,480	674,777		674,777	(138,140)	536,637			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,288,047	630,522	1,960,868	4,879,437		4,879,437	(223,008)	4,656,429			45

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

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	(107)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,241)	30		9
10	Interest and Other Investment Income	(365)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,936)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(185,441)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (218,090)		\$	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)	(4,918)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,918)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (223,008)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs	\$ (9,335)	43	1
2	X-Rays	(4,840)	43	2
3	Disallow PAC donations	(1,887)	43	3
4	Disallow Donations other	(1,100)	43	4
5	Disallow TV Expenses	(8,260)	43	5
6	Goodwill	(3,883)	43	6
7	Nonallowable Legal	(14,811)	19	7
8	To Disallow nonallowable dialysis	(3,960)	39	8
9	Lobby Expense	(2,401)	20	9
10	Admissions	(43,600)	12	10
11	Real Estate	(1,235)	33	11
12	Therapy	(89,939)	39	12
13	Nonallowable Seminar	(187)	24	13
14	Medical Supply	(3)	10	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	(185,441)		49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Holgeir J. Oksnevad	100	N/A		Medina Manor Building, Inc.	Durand	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	\$	Medina Manor Building, Inc.		\$ 3,182	\$ 3,182	1
2	V	34	Rent	8,100	Medina Manor Building, Inc.			(8,100)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 8,100			\$ 3,182	\$ * (4,918)	14

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Holgeir Oksnevad	President	Administrator	0.00	None	50+	100.00	Salary	\$ 137,800	17(1)	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 137,800		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/2016 Ending: 2/31/2016

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 ☒
- 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3	N/A									3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

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	\$ 1,289,648	\$ 1,092,182	5/15/2017	0.0595	\$ 68,183	1
2	Kubota		X	Mower	\$ 577.60	5/13/13	38,624	3,436	5/13/17			2
3	Kubota		X	RTV	\$ 577.68	4/13/14	22,100		4/13/18			3
4												4
5												5
	Working Capital											
6	Davis Bank		X	Working Capital	None	6/27/12	200,105	312,150	11/30/2017	0.0500	12,178	6
7	Durand Bank		X	Working Capital	None	08/14/12	350,000	535,846	11/14/2017	0.0500	24,852	7
8	H. Oksnevad	X		Working Capital	None	Varies	Varies	141,943	Demand	None	3,481	8
9	TOTAL Facility Related				\$10,377.28		\$ 1,900,477	\$ 2,085,557			\$ 108,694	9
	B. Non-Facility Related*											
10												10
11								Finance Charges			174	11
12								Interest Income			(365)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (191)	14
15	TOTALS (line 9+line14)						\$ 1,900,477	\$ 2,085,557			\$ 108,503	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.)

B. Real Estate Taxes

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.

2015 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 2015 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 2015.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. <u>05-15-251-003</u>	<u>Medina Manor Building</u>	\$ <u>1,286.34</u>	\$ <u>1,286.34</u>
2. <u>05-15-251-008</u>	<u>Medina Manor Building</u>	\$ <u>1,258.74</u>	\$ <u>1,258.74</u>
3. <u>05-15-251-005</u>	<u>Medina Manor Building</u>	\$ <u>51,958.76</u>	\$ <u>51,958.76</u>
4. <u>05-15-251-007</u>	<u>Medina Manor Building</u>	\$ <u>3,657.60</u>	\$ <u>3,657.60</u>
5. <u>05-15-251-006</u>	<u>Medina Manor Building</u>	\$ <u>1,320.82</u>	\$ <u>1,320.82</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>59,482.26</u></u>	\$ <u><u>59,482.26</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet: 24,000

B. General Construction Type: Exterior BrickFrame Masonry, Fire ResortNumber of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

Medina Manor Apartments

Retirement Apartments

22 units

20,000 Sq. Ft.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	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:

01/01/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	64		1965	1965	\$ 488,644	\$	30	\$	\$	488,644
5	25		1980	1980	158,173		30			158,173
6										
7					Allocated from Medina Manor Building Fund			3,182	3,182	
8										
	Improvement Type**									
9	Building Improvements		1968		675		15			675
10	Building Improvements		1974		861		10			861
11	Building Improvements		1975		1,547		10			1,547
12	Building Improvements		1976		345		9			345
13	Building Improvements		1977		12,614		21			12,614
14	Building Improvements		1977		2,793		8			2,793
15	Building Improvements		1979		2,620		7			2,620
16	Building Improvements		1980		24,465		20			24,465
17	Building Improvements		1980		2,137		7			2,137
18	Building Improvements		1981		20,211		15			20,211
19	Building Improvements		1982		2,305		20			2,305
20	Building Improvements		1983		705		5			705
21	Building Improvements		1985		980		10			980
22	Building Improvements		1985		3,091		20			3,091
23	Building Improvements		1986		17,543		10			17,543
24	Building Improvements		1987		56,373		20			56,373
25	Building Improvements		1988		14,212		20			14,212
26	Building Improvements		1989		30,063		20			30,063
27	Building Improvements		1990		1,601		20			1,601
28	Building Improvements		1991		51,619		20			51,619
29	Building Improvements		1991		11,626		20			11,626
30	Building Improvements		1992		39,070		20			39,070
31	Building Improvements		1992		3,295		20			3,295
32	Building Improvements		1992		19,372		20			19,372
33	Building Improvements		1992		23,809		20			23,809
34										
35										
36						-				

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning:

01/01/2016 Ending: 12/31/2016

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	
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	\$ -		\$ 3,182	\$ 3,182	\$ 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:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,341,158	\$		\$ 3,182	\$ 3,182	\$ 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	500	15	500		15,000	11
12	Dumpster Gate Frames	2001	1,650	55	15	55		1,650	12
13	Dumpster Concrete Platform	2001	3,700	123	15	123		3,700	13
14	Stone Wall	2001	1,665	56	15	56		1,665	14
15	Video Surveillance	2002	14,865	991	15	991		14,370	15
16	Wrought Iron Fence	2002	5,105	340	15	340		4,934	16
17	Nurses Call System	2002	12,726	848	15	848		12,301	17
18	Custom Doors	2002	9,427	628	15	628		9,112	18
19	Windows Framing	2003	11,656	777	15	777		10,491	19
20	Roof	2003	7,470	498	15	498		6,723	20
21	Alarm Installation	2003	12,730	849	15	849		11,457	21
22	Cabinets	2004	504	34	15	34		420	22
23	Surveillance Cameras	2004	578	39	15	39		482	23
24	Time Clock	2004	10,000	667	15	667		8,334	24
25	Latches	2004	8,923	595	15	595		7,436	25
26	Exhaust Hood	2004	4,290	286	15	286		3,575	26
27	Bath Call Light	2004	1,229	82	15	82		1,024	27
28	Ventilator	2004	1,038	69	15	69		864	28
29	Driveway	2004	4,000	267	15	267		3,333	29
30	Sidewalk & Driveway	2005	5,209	347	15	347		3,993	30
31	Wiring & Outlets	2005	8,903	594	15	594		6,826	31
32	Windows	2005	1,911	127	15	127		1,465	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,507,007	\$ 8,772		\$ 11,954	\$ 3,182	\$ 1,493,583	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:

01/01/2016 Ending: 12/31/2016

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	\$ 8,772		\$ 11,954	\$ 3,182	\$ 1,493,583	1
2	<u>Flag Poles</u>	2005	4,362	291	15	291		3,344	2
3									3
4	<u>Fire Alarm System</u>	2006	12,455	830	15	830		8,718	4
5	<u>Doors and Gaskets</u>	2006	6,545	436	15	436		4,581	5
6	<u>Water Softner</u>	2006	965	64	15	64		675	6
7	<u>Landscaping Improvements</u>	2006	2,377	158	15	158		1,664	7
8	<u>Timeclock</u>	2006	20,715	1,381	15	1,381		14,501	8
9	<u>Roofing</u>	2006	1,350	90	15	90		945	9
10	<u>Fire Door</u>	2006	965	64	15	64		675	10
11	<u>Hot Water Storage Tank</u>	2006	11,998	800	15	800		8,399	11
12	<u>A/C Compressor</u>	2006	1,777	118	15	118		1,243	12
13	<u>Fire Alarm Panel</u>	2006	3,200	213	15	213		2,240	13
14									14
15	<u>Roofing</u>	2007	2,675	178	15	178		1,694	15
16	<u>Fire Safety Doors</u>	2007	3,111	207	15	207		1,970	16
17	<u>Kitchen Cabinets</u>	2007	4,131	275	15	275		2,616	17
18	<u>Water Treatment System</u>	2007	11,465	764	15	764		7,261	18
19	<u>Timeclock system</u>	2007	4,034	269	15	269		2,555	19
20									20
21	<u>Sprinkler</u>	2008	33,686	2,246	15	2,246		19,089	21
22	<u>Tub room improvements</u>	2008	20,275	1,352	15	1,352		11,490	22
23	<u>Generator</u>	2008	44,840	2,989	15	2,989		25,409	23
24	<u>Wiring</u>	2008	12,182	812	15	812		6,903	24
25	<u>Pipe Insulation</u>	2008	6,807	454	15	454		3,858	25
26	<u>Fire Stops</u>	2008	4,368	291	15	291		2,475	26
27	<u>Sidewalk replacement</u>	2008	4,805	320	15	320		2,722	27
28	<u>Dining Room Doors</u>	2008	8,397	560	15	560		4,759	28
29	<u>Ceiling work</u>	2008	4,374	292	15	292		2,479	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,738,866	\$ 24,226		\$ 27,408	\$ 3,182	\$ 1,635,848	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:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,738,866	\$ 24,226		\$ 27,408	\$ 3,182	\$ 1,635,848	1
2	Ceiling Work - North/Center Hall	2009	25,166	1,678	15	1,678		12,583	2
3	A/C West Hall	2009	87,956	5,864	15	5,864		43,978	3
4	Built in Cabinets	2009	4,852	323	15	323		2,425	4
5	A/C Dining Room	2009	8,500	567	15	567		4,250	5
6	Fire Alarm	2009	2,607	174	15	174		1,304	6
7	Sprinkler	2009	5,260	351	15	351		2,630	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		34,462	10
11	A/C Project - North Hall	2010	51,265	3,418	15	3,418		22,215	11
12	Sprinkler System	2010	42,195	2,813	15	2,813		18,285	12
13	Updating - Center Hall	2010	55,277	3,685	15	3,685		23,953	13
14	A/C Project - Downstairs	2010	66,718	4,448	15	4,448		28,911	14
15	South Hall A/C	2010	31,149	2,077	15	2,077		13,498	15
16	Final - Sprinkler System	2010	7,060	471	15	471		3,060	16
17	Updating - Center Hall	2010	38,562	2,571	15	2,571		16,710	17
18	Updating - Downstairs	2010	21,568	1,438	15	1,438		9,346	18
19	Updating - North Hall	2010	15,151	1,010	15	1,010		6,565	19
20	Updating - South Hall	2010	26,058	1,737	15	1,737		11,291	20
21	Transfer from CIP	2010	84,287	5,619	15	5,619		36,524	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	\$ 67,772		\$ 70,954	\$ 3,182	\$ 1,932,826	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:

01/01/2016 Ending: 12/31/2016

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,397,012	\$ 67,772		\$ 70,954	\$ 3,182	\$ 1,932,826	1
2	Lower level A/C Installation	2011	61,000	4,067	15	4,067		22,367	2
3	South hall A/C work Installation	2011	33,464	2,231	15	2,231		12,270	3
4	Updated-South hall eletrical and Plumbing	2011	60,338	4,023	20	4,023		22,124	4
5	Updated-North hall bathroom-flooring,paint and electrical	2011	9,626	642	20	642		3,530	5
6	Updated-Landscaping	2011	13,853	924	10	924		5,080	6
7	Updated West hall-Bathroom and water softner	2011	4,043	270	20	270		1,483	7
8	Downstairs bathrooms-Flooring,plumbing	2011	11,187	746	20	746		4,102	8
9	Addition to Sprinkler- south hall	2011	8,135	542	20	542		2,982	9
10	Heating equipment Installation on lower level	2011	21,929	1,462	20	1,462		8,041	10
11	North hall flooring	2011	11,519	768	20	768		4,224	11
12	Updated Outside leasehold courtyard- benches,garden	2011	12,571	838	10	838		4,609	12
13	Updated and replaced Roof & gutters	2011	80,797	5,386	10	5,386		29,625	13
14	Updated South hall bathroom-Flooring,door,windows	2011	16,442	1,096	20	1,096		6,029	14
15	Dialysis project retrofit room	2011	25,000	1,667	15	1,667		9,167	15
16	Ozone unit for washing machines	2011	17,000	1,133	10	1,133		6,233	16
17	Water softener	2011	10,939	729	20	729		4,011	17
18	Water heater system installed including plumbing and piping	2011	41,466	2,764	15	2,764		15,204	18
19									19
20	Labor & Repair to Heating Units	2012	4,875	325	15	325		1,462	20
21	North & Center Hall:Labor, paint, flooring, wallpaper, etc.	2012	26,712	1,781	15	1,781		8,014	21
22	Dialysis Unit Remodel: Labor, flooring, paint, electrical, etc.	2012	168,368	11,225	15	11,225		50,511	22
23	West Hall: Plumbing, bathroom fixtures, electrical,	2012	49,521	3,301	15	3,301		14,856	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		4,452	26
27	Updated West Hall: ceiling, flooring, electric, paint & labor	2013	45,448	2,272	15	2,272		7,953	27
28	West Hall - Project	2013	20,208	1,010	15	1,010		3,536	28
29	South Shower Rooms Update:Labor,tile,grab bars,plumbing	2013	13,289	664	15	664		2,325	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		2,548	31
32	West Hall Improvements: ceiling, bathrooms, electric, paint,	2013	8,182	1,169	15	1,169		4,091	32
33	wallpaper, wood, trim, handrails, baseboards, etc.								33
34	TOTAL (lines 1 thru 33)		\$ 3,212,920	\$ 120,807		\$ 123,989	\$ 3,182	\$ 2,193,655	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:

01/01/2016 Ending: 12/31/2016

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	\$ 120,807		\$ 123,989	\$ 3,182	\$ 2,193,655	1
2	Updated Center Hall	2014	16,330	1,089	15	1,089		2,722	2
3	- electric, paper, paint, misc								3
4	- flooring								4
5	Updated general heating	2014	31,193	2,080	15	2,080		5,199	5
6	- Equipment (units for heating)								6
7	- Misc (supplies)								7
8	Updated general upstairs	2014	33,945	2,263	15	2,263		5,658	8
9	- electric, paper, paint, misc								9
10	- flooring								10
11	Updated outside of building	2014	9,217	614	15	614		1,536	11
12	- court yard and entrance								12
13	Roof repair	2014	14,770	1,477	10	1,477		3,693	13
14									14
15	Roof - North Hall	2015	19,636	1,964	10	1,964		2,946	15
16	Updated Lower Level, Resident Dining Room	2015	32,842	2,189	15	2,189		3,284	16
17	- electric, paper, paint, misc								17
18	- flooring								18
19	Updated General upstairs, Main Lounge	2015	7,747	516	15	516		774	19
20	- electric, paper, paint, misc								20
21									21
22									22
23	Disallowed portion due to outpatient therapy					(4,522)	(4,522)		23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33	To reconcile to financial statements			12,719			(12,719)		33
34	TOTAL (lines 1 thru 33)		\$ 3,378,600	\$ 145,719		\$ 131,660	\$ (14,059)	\$ 2,219,468	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$708,046	\$45,632	\$45,632	\$-	5-10	\$545,743	71
72	Current Year Purchases				-	5		72
73	Fully Depreciated Assets				-			73
74	Assets Disposed	(242,173)			-		(242,173)	74
75	TOTALS	\$465,873	\$45,632	\$45,632	\$-		\$303,570	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	\$	\$	\$-		\$18,008	76
77							-			77
78	See Schedule 13A	Various	Various	156,340	16,705	16,705	-		151,062	78
79							-			79
80	TOTALS			\$174,348	\$16,705	\$16,705	\$-		\$169,070	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,021,869	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$208,056	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$193,997	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(14,059)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$2,692,108	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: 12/31/2016

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	2,969	2,969	-	5	29,688
Administrative	Ford Focus	2011	28,877	2,888	2,888	-	5	28,877
Maintenance	Dodge Truck	2011	39,797	3,980	3,980	-	5	39,797
Maintenance	Snow Plow & Salt Spreader	2011	5,525	552	552	-	5	5,525
Maintenance	Kubuta Mower	2012	13,476	2,695	2,695	-	5	12,128
Maintenance	M&W Industrial - Forklift	2012	7,495	1,499	1,499	-	5	6,746
Maintenance	Trailer	2013	10,608	2,122	2,122	-	5	7,427
						-		
TOTAL			156,340	16,705	16,705	-		151,062

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.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A.
9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? YES NO X
16. Rental Amount for movable equipment: \$4,831 Description: Office Equipment
(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

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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?

☐ 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

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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	\$	906	\$ 65,230	\$	906	\$ 65,230	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		287	20,668		287	20,668	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2)(3)	hrs		1,423	102,457	3,701	1,423	106,158	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				117,597		117,597	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): See Sch 16A	39(2)					29,039		29,039	12
13	Other (specify):									13
14	TOTAL			\$	2,616	\$ 188,355	\$ 150,337	2,616	\$ 338,692	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: 12/31/2016

Schedule 16A

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

Description	Units	Amount
Oxygen - MEDICAL - In House		19,637
Doctor Visits - Medical - VA		7,938
Non Covered Meds - Medical - Medicaid/IPAC		1,464
Total - Line 12	-	29,039

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,072	\$ 7,286	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,432,257	1,432,257	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,181	3,181	6
7	Other Prepaid Expenses	4,630	4,630	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	26,413	26,413	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,471,553	\$ 1,473,767	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	2,731,783	15
16	Equipment, at Historical Cost	771,196	640,221	16
17	Accumulated Depreciation (book methods)	(1,996,038)	(2,692,108)	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)	\$ 1,293,454	\$ 1,329,761	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,765,007	\$ 2,803,528	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 254,085	\$ 254,085	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,029	1,029	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	681	681	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,421	22,421	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)	\$ 340,216	\$ 340,216	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,085,557	2,085,557	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,085,557	\$ 2,085,557	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,425,773	\$ 2,425,773	46
47	TOTAL EQUITY(page 18, line 24)	\$ 339,234	\$ 377,755	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,765,007	\$ 2,803,528	48

*(See instructions.)

Facility Name: Medina Nursing Center
IDPH License ID Number: 0011551
Fiscal Year End: 12/31/2016

Schedule 17A

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

Description	After	
	Operating	Consolidation
Employee Uniform Purchases	1,705	1,705
Note Due From CNA First	24,708	24,708
Total - Line 9	26,413	26,413

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 741,284	1
2	Restatements (describe):		2
3	Prior period adjustment	(1,288)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 739,996	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(400,762)	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)	\$ (400,762)	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)	\$ 339,234	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,645,308	1
2	Discounts and Allowances for all Levels	(1,839,104)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,806,204	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,154,707	6
7	Oxygen	61,261	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,215,968	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	144,683	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,208	19
20	Radiology and X-Ray	4,538	20
21	Other Medical Services	216,811	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 376,240	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	365	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 365	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	46,979	28
28a	<u>See Schedule 19A</u>	32,919	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 79,898	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,478,675	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	994,204	31
32	Health Care	1,915,851	32
33	General Administration	904,360	33
	B. Capital Expense		
34	Ownership	390,245	34
	C. Ancillary Expense		
35	Special Cost Centers	489,023	35
36	Provider Participation Fee	185,754	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,879,437	40
41	Income before Income Taxes (line 30 minus line 40)**	(400,762)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (400,762)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 144,687	44
45	Private Pay - Net Inpatient Revenue	2,476,710	45
46	Medicare - Net Inpatient Revenue	(132,786)	46
47	Other-(specify) <u>Hospice</u>	227,064	47
48	Other-(specify) <u>See Schedule 19C</u>	90,529	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,806,204	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: 12/31/2016

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Equipment Rental - Private	4,778
Equipment Rental - Medicaid/IPAC	20,706
Equipment Rental - Medicare A	920
Equipment Rental - HMO Managed Care	1,174
Equipment Rental - Hospice	17,491
Equipment Rental - VA	1,910
Total - Line 28	46,979

XVII. Income Statement

Line 28a Other Expenses (specify):

Description	Amount
Miscellaneous - Private	8,720
Transportation - Medcaid/IPAC	8,025
Miscellaneous - HMO Managed Care	33
Misc - VA	22
Transportation - VA	515
Miscellaneous Sales - Apt, Meals, Other	15,604
Total - Line 37	32,919

Facility Name: Medina Nursing Center
IDPH License ID Number: 0011551
Fiscal Year End: 12/31/2016

Schedule 19C

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

Description	Amount
Contractual Allowance - VA	(221,628)
Contractual Allowance - Outpatien	(243,461)
Room & Board	555,618
Total - Line 48	90,529

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	1,909	2,093	\$ 91,605	\$ 43.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,473	13,616	310,122	22.78	3
4	Licensed Practical Nurses	5,965	6,375	151,541	23.77	4
5	CNAs & Orderlies	49,860	52,429	711,230	13.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,564	8,157	99,693	12.22	10
11	Social Service Workers	3,920	4,160	93,520	22.48	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	44,824	21.55	13
14	Head Cook	5,456	5,965	68,069	11.41	14
15	Cook Helpers/Assistants	14,944	15,452	156,615	10.14	15
16	Dishwashers					16
17	Maintenance Workers	7,116	8,438	96,372	11.42	17
18	Housekeepers	9,385	9,207	117,136	12.72	18
19	Laundry	4,115	5,348	49,783	9.31	19
20	Administrator	2,940	3,120	137,800	44.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,945	6,286	106,730	16.98	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	2,877	3,177	53,007	16.68	31
32	Other Health Care					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,429	145,903	\$ 2,288,047 *	\$ 15.68	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 7,532	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	4,326	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	20	1,536	11(3)	44
45	Social Service Consultant	12	922	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	32	\$ 29,916		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	2,322	91,421	10(3)	51
52	Certified Nurse Assistants/Aides	4,326	139,619	10(3)	52
53	TOTAL (lines 50 - 52)	6,648	\$ 231,040		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Holgeir Oksnevad	Administrator	100	\$ 137,800	Workers' Compensation Insurance	\$	39,692	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance		13,079	Advertising: Employee Recruitment	6,035	
				FICA Taxes		172,231	Health Care Worker Background Check		
				Employee Health Insurance		110,979	(Indicate # of checks performed 31)	493	
				Employee Meals			Patient Background Checks	66 1,056	
				Illinois Municipal Retirement Fund (IMRF)*			Misc. Licenses & Fees	1,474	
				Employee Retirement		51,097	Misc Dues & Subscriptions	400	
				Employee Relations		4,189	IL Secretary of State License	1,087	
				Employee Physicals		3,348	IHCA	6,079	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,800				Less: Public Relations Expense	(2,401)	
B. Administrative - Other							Non-allowable advertising	()	
Description			Amount				Yellow page advertising	()	
N/A			\$				TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 18,203		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 394,615		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Sch21C			\$ 76,983	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name: Medina Nursing Center
IDPH License ID Number: 0011551
Fiscal Year End: 12/31/2016

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	28,160
Reno & Zahm LLP	Legal	12,841
Duane Morris LLP	Legal	1,623
Durand State Bank	Legal	4,500
Point Click Care	Computer Services	18,840
eHealth Data Solutions	Computer Services	675
Ability Network Inc.	Computer Services	6,453
PowWeb	Computer Services	305
Infinisource, Inc	Computer Services	601
Sage Abra	Computer Services	2,985
Total (agree to Schedule V, line 19, column 3)		76,983
Less: Non-Allowable Legal Fees		(14,811)
Total (agree to Schedule V, line 19, column 8)		62,172

XX. GENERAL INFORMATION:

- | | |
|--|---|
| <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u>
If YES, give association name and amount. <u>IHCA - \$6,079</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>No</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u>
What was the average life used for new equipment added during this period? <u>N/A</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>25,180</u> Line <u>10(2)</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation.</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u>
If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>NO</u> <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>185,754</u>
This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation.</p> | <p>(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? <u>Yes</u></p> <p>(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? <u>No</u> 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.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ <u>N/A</u></p> <p>(16) Travel and Transportation
a. Are there costs included for out-of-state travel? <u>No</u>
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u>
c. What percent of all travel expense relates to transportation of nurses and patients? <u>N/A</u>
d. Have vehicle usage logs been maintained? <u>Adequate records have been maintained</u>
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>No</u>
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u>
g. Does the facility transport residents to and from day training? <u>No</u>
Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u>
Firm Name: <u>N/A</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(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. <u>Yes</u>
Attach invoices and a summary of services for all architect and appraisal fees</p> |
|--|---|