

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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 StDurand61024

County: Winnebago

Telephone Number: (815) 248-2151Fax #: (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 SpringbornTelephone 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 01/01/2025 to 12/31/2025 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)

(Telephone)

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406

(Date)

(Date)

1450 American Way Suite 1400 Schaumburg, IL 60173-6084

(847) 517-7070Fax #: (847) 517-7067

Phone # (217) 782-1630

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

1

2

3

4

	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	89	Skilled (SNF)	89	32,485	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	89	TOTALS	89	32,485	7

B. Census-For the entire report period.

1

2

3

4

5

6

7

8

9

	Level of Care	Patient Days by Level of Care and Primary Source of Payment									
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total		
				Medicaid Primary	Medicare Primary						
8	SNF	53	223			315	662		1,253	8	
9	SNF/PED									9	
10	ICF	1,257	5,276			2,719		6,639	15,891	10	
11	ICF/DD									11	
12	SC									12	
13	DD 16 OR LESS									13	
14	TOTALS	1,310	5,499			3,034	662	6,639	17,144	14	

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)

52.78%

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 ☒ NO ☐

Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1965

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date N/A NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter certified beds.

number of certified beds 89

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	388,298	24,603	8,308	421,209		421,209		421,209			1
2	Food Purchase		232,138		232,138		232,138	(5,709)	226,429			2
3	Housekeeping	133,613	22,259		155,872		155,872		155,872			3
4	Laundry	60,952	3,634		64,586		64,586		64,586			4
5	Heat and Other Utilities			119,085	119,085		119,085		119,085			5
6	Maintenance	128,861	12,725	127,786	269,372		269,372	880	270,252			6
7	Other (specify):*											7
8	TOTAL General Services	711,724	295,359	255,179	1,262,262		1,262,262	(4,829)	1,257,433			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,456,037	86,966	900,557	2,443,560		2,443,560		2,443,560			10
10a	Therapy											10a
11	Activities	70,875	166	2,458	73,499		73,499		73,499			11
12	Social Services	131,553		1,726	133,279		133,279		133,279			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,658,465	87,132	919,141	2,664,738		2,664,738		2,664,738			16
	C. General Administration											
17	Administrative	128,900		126,337	255,237		255,237	(126,337)	128,900			17
18	Directors Fees											18
19	Professional Services			100,245	100,245		100,245	16,302	116,547			19
20	Dues, Fees, Subscriptions & Promotions			28,458	28,458		28,458	(971)	27,487			20
21	Clerical & General Office Expenses	155,941	7,128	27,442	190,511		190,511	74,257	264,768			21
22	Employee Benefits & Payroll Taxes			373,312	373,312		373,312	8,208	381,520			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,333	5,333		5,333		5,333			24
25	Other Admin. Staff Transportation			17,969	17,969		17,969		17,969			25
26	Insurance-Prop.Liab.Malpractice			185,158	185,158		185,158	1,662	186,820			26
27	Other (specify):*											27
28	TOTAL General Administration	284,841	7,128	864,254	1,156,223		1,156,223	(26,879)	1,129,344			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,655,030	389,619	2,038,574	5,083,223		5,083,223	(31,708)	5,051,515			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation							128,311	128,311			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,753	53,753		53,753	63,452	117,205			32
33	Real Estate Taxes			63,424	63,424		63,424		63,424			33
34	Rent-Facility & Grounds			132,900	132,900		132,900	(132,900)				34
35	Rent-Equipment & Vehicles			13,397	13,397		13,397		13,397			35
36	Other (specify):*											36
37	TOTAL Ownership			263,474	263,474		263,474	58,863	322,337			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		76,746	209,871	286,617		286,617	(91,917)	194,700			39
40	Barber and Beauty Shops			3,048	3,048		3,048		3,048			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			224,988	224,988		224,988		224,988			42
43	Other (specify):* Non-Allowable Cost			52,184	52,184		52,184	(52,184)				43
44	TOTAL Special Cost Centers		76,746	490,091	566,837		566,837	(144,101)	422,736			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,655,030	466,365	2,792,139	5,913,534		5,913,534	(116,946)	5,796,588			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				4
5	Telephone, TV & Radio in Resident Rooms	(15,826)	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	128,311	30		9
10	Interest and Other Investment Income	(184)	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	(16,250)	43		18
19	Entertainment				19
20	Contributions	(1,887)	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	(8,749)	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	(112,908)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (27,493)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(89,453)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (89,453)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (116,946)		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	Political Action Committee Payments	\$ (2,882)	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Labs	(7,291)	43	3
4	Goodwill	(1,376)	43	4
5	Misc Revenue Offset	(5,709)	2	5
6	Federal Income Tax	(805)	43	6
7	Therapy	(91,917)	39	7
8	Non-allowable legal	(2,928)	19	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				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	(112,908)		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
See Ownership-1		Alpine Fireside Health Center, Ltd.	Rockford	Medina Manor Building, Inc.	Durand	Lessor
				Oxmati Management	Rockford	Mgmt Co

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.		\$	\$	1
2	V	34	Building Rent	132,900	Medina Manor Building, Inc.			(132,900)	2
3	V	19	Accounting / Legal / Other Professional Fees		Medina Manor Building, Inc.		18,725	18,725	3
4	V	32	Interest		Medina Manor Building, Inc.		61,049	61,049	4
5	V	20	Dues, Fees, Subscriptions & Promotions		Medina Manor Building, Inc.		77	77	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			\$ 132,900			\$ 79,851	\$ * (53,049)	14

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

VII. RELATED PARTIES (continued)

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)	
15	V	6	Maintenance	\$	Oxmati Management		\$ 880	\$ 880	15
16	V	17	Management Fees	126,337	Oxmati Management			(126,337)	16
17	V	19	Professional Fees		Oxmati Management		505	505	17
18	V	20	Dues & Subscriptions		Oxmati Management		1,834	1,834	18
19	V	21	Clerical Salaries		Oxmati Management		67,965	67,965	19
20	V	21	Office Supplies		Oxmati Management		6,292	6,292	20
21	V	22	Employee Benefits		Oxmati Management		8,208	8,208	21
22	V	26	Insurance-Prop.Liab.Malpractice		Oxmati Management		1,662	1,662	22
23	V	32	Interest		Oxmati Management		2,587	2,587	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 126,337			\$ 89,933	\$ * (36,404)	39

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

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Holgeir Oksnevad	President	Administrator	100.00	53,505	20	50.00	Mgmt Fees	\$ 46,039	L21,C7	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	\$ 46,039		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:

01/01/2025

Ending:

12/31/2025

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

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 Oxmati Management
Street Address 5247 American Road
City / State / Zip Code Rockford, IL 61109-6312
Phone Number (815) 306-8039
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	6	Maintenance	Management Fees	370,837	8	\$ 2,635	\$	123,907	\$ 880	1
2	19	Professional Fees	Management Fees	370,837	8	1,512		123,907	505	2
3	20	Dues & Subscriptions	Management Fees	370,837	8	5,488		123,907	1,834	3
4	21	Clerical Salaries	Management Fees	370,837	8	203,410	203,410	123,907	67,965	4
5	21	Office Supplies	Management Fees	370,837	8	18,831		123,907	6,292	5
6	22	Employee Benefits	Management Fees	370,837	8	24,564		123,907	8,208	6
7	26	Insurance-Prop.Liab.Malpractice	Management Fees	370,837	8	4,975		123,907	1,662	7
8	32	Interest	Management Fees	370,837	8	7,744		123,907	2,587	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					\$ 269,159	\$ 203,410		\$ 89,933	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	Solutions Bank	X		Mortgage		05/20/22	\$ 1,530,000	\$ 1,387,044	5/1/2027	0.0595	\$ 61,049	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Solutions Bank		X	LOC	None	11/7/2022	800,000	755,865	11/10/2025	6.0000	51,132	6
7	Oksnevad		X	Working Capital	None			261,000			1,117	7
8	Solutions Bank		x	Working Capital	Interest Only	11/30/2023	500,000	16,000	11/30/2025	0.0825		8
9	TOTAL Facility Related						\$ 2,830,000	\$ 2,419,909			\$ 113,298	9
	B. Non-Facility Related*											
10								Bnak Charges			1,504	10
11								Allocated from Mgmt Co.			2,587	11
12								Offset Interest Income			(184)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 3,907	14
15	TOTALS (line 9+line14)						\$ 2,830,000	\$ 2,419,909			\$ 117,205	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 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.)		2024	\$	63,424	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,424	3
4. Real Estate Tax accrual used for 2025 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.			\$	63,424	7
Assessed Value from Real Estate Tax Bill: 2024 63,424 8					
Real Estate Tax Bill for Calendar Year: 2020 55,370 9					
2021 55,493 10					
2022 53,660 11					
2023 57,965 12					
2024 63,424 13					
		14	FROM R. E. TAX STATEMENT FOR 2024 \$		14
		15	PLUS APPEAL COST FROM LINE 5 \$		15
		16	LESS REFUND FROM LINE 6 \$		16
		17	AMOUNT TO USE FOR RATE CALCULATION \$		17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Medina Nursing Center 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 2024 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 2024.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-15-251-003</u>	<u>Medina Manor Building</u>	\$ <u>1,407.00</u>	\$ <u>1,407.00</u>
2. <u>05-15-251-008</u>	<u>Medina Manor Building</u>	\$ <u>143.00</u>	\$ <u>143.00</u>
3. <u>05-15-251-011</u>	<u>Medina Manor Building</u>	\$ <u>61,874.00</u>	\$ <u>61,874.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>63,424.00</u></u>	\$ <u><u>63,424.00</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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:24,000

B. General Construction Type:ExteriorBrickFrameMasonry, Fire Resort

Number of Stories2

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. List the bed capacity for the building if it differs from the licensed total.

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Y

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

No

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESNOX

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

K. 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:

01/01/2025

Ending:

12/31/2025

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	4	
5	25		1980	1980	158,173		30			158,173	5	
6											6	
7											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:

01/01/2025

Ending:

12/31/2025

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	\$		\$	\$	\$ 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:

01/01/2025

Ending:

12/31/2025

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	\$		\$	\$	\$ 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			504	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		15			4,290	26
27	Bath Call Light	2004	1,229		15			1,229	27
28	Ventilator	2004	1,038		15			1,038	28
29	Driveway	2004	4,000		15			4,000	29
30	Sidewalk & Driveway	2005	5,209		15			5,209	30
31	Wiring & Outlets	2005	8,903		15			8,903	31
32	Windows	2005	1,911		15			1,911	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,507,007	\$		\$	\$	\$ 1,507,007	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:

01/01/2025

Ending:

12/31/2025

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	\$		\$	\$	\$ 1,507,007	1
2	<u>Flag Poles</u>	2005	4,362		15			4,362	2
3									3
4	<u>Fire Alarm System</u>	2006	12,455		15			12,455	4
5	<u>Doors and Gaskets</u>	2006	6,545		15			6,545	5
6	<u>Water Softner</u>	2006	965		15			965	6
7	<u>Landscaping Improvements</u>	2006	2,377		15			2,377	7
8	<u>Timeclock</u>	2006	20,715		15			20,715	8
9	<u>Roofing</u>	2006	1,350		15			1,350	9
10	<u>Fire Door</u>	2006	965		15			965	10
11	<u>Hot Water Storage Tank</u>	2006	11,998		15			11,998	11
12	<u>A/C Compressor</u>	2006	1,777		15			1,777	12
13	<u>Fire Alarm Panel</u>	2006	3,200		15			3,200	13
14									14
15	<u>Roofing</u>	2007	2,675		15			2,675	15
16	<u>Fire Safety Doors</u>	2007	3,111		15			3,111	16
17	<u>Kitchen Cabinets</u>	2007	4,131		15			4,131	17
18	<u>Water Treatment System</u>	2007	11,465		15			11,465	18
19	<u>Timeclock system</u>	2007	4,034		15			4,034	19
20									20
21	<u>Sprinkler</u>	2008	33,686		15			33,686	21
22	<u>Tub room improvements</u>	2008	20,275		15			20,275	22
23	<u>Generator</u>	2008	44,840		15			44,840	23
24	<u>Wiring</u>	2008	12,182		15			12,182	24
25	<u>Pipe Insulation</u>	2008	6,807		15			6,807	25
26	<u>Fire Stops</u>	2008	4,368		15			4,368	26
27	<u>Sidewalk replacement</u>	2008	4,805		15			4,805	27
28	<u>Dining Room Doors</u>	2008	8,397		15			8,397	28
29	<u>Ceiling work</u>	2008	4,374		15			4,374	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,738,866	\$		\$	\$	\$ 1,738,866	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:

01/01/2025

Ending:

12/31/2025

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	\$		\$	\$	\$ 1,738,866	1
2	Ceiling Work - North/Center Hall	2009	25,166	1,678	15		(1,678)	25,166	2
3	A/C West Hall	2009	87,956	5,864	15		(5,864)	87,956	3
4	Built in Cabinets	2009	4,852	323	15		(323)	4,852	4
5	A/C Dining Room	2009	8,500	567	15		(567)	8,500	5
6	Fire Alarm	2009	2,607	174	15		(174)	2,607	6
7	Sprinkler	2009	5,260	351	15		(351)	5,260	7
8	Carpet	2009	4,988		5			4,988	8
9									9
10	A/C Project - Center Hall	2010	79,527	5,302	15	2,649	(2,653)	79,527	10
11	A/C Project - North Hall	2010	51,265	3,418	15	1,706	(1,712)	51,265	11
12	Sprinkler System	2010	42,195	2,813	15	1,406	(1,407)	42,195	12
13	Updating - Center Hall	2010	55,277	3,685	15	1,844	(1,841)	55,277	13
14	A/C Project - Downstairs	2010	66,718	4,448	15	2,223	(2,225)	66,718	14
15	South Hall A/C	2010	31,149	2,077	15	1,035	(1,042)	31,149	15
16	Final - Sprinkler System	2010	7,060	471	15	232	(239)	7,060	16
17	Updating - Center Hall	2010	38,562	2,571	15	1,284	(1,287)	38,562	17
18	Updating - Downstairs	2010	21,568	1,438	15	718	(720)	21,568	18
19	Updating - North Hall	2010	15,151	1,010	15	506	(504)	15,151	19
20	Updating - South Hall	2010	26,058	1,737	15	871	(866)	26,058	20
21	Transfer from CIP	2010	84,287	5,619	15	2,811	(2,808)	84,287	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	\$ 43,546		\$ 17,285	\$ (26,261)	\$ 2,397,012	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:

01/01/2025 Ending: 12/31/2025

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	\$ 43,546		\$ 17,285	\$ (26,261)	\$ 2,397,012	1
2	Lower level A/C Installation	2011	61,000	4,067	15	4,067		58,970	2
3	South hall A/C work Installation	2011	33,464	2,231	15	2,231		32,349	3
4	Updated-South hall eletrical and Plumbing	2011	60,338	4,023	20	4,023		58,331	4
5	Updated-North hall bathroom-flooring,paint and electrical	2011	9,626	642	20	642		9,308	5
6	Updated-Landscaping	2011	13,853	924	10	924		13,396	6
7	Updated West hall-Bathroom and water softner	2011	4,043	270	20	270		3,913	7
8	Downstairs bathrooms-Flooring,plumbing	2011	11,187	746	20	746		10,816	8
9	Addition to Sprinkler- south hall	2011	8,135	542	20	542		7,860	9
10	Heating equipment Installation on lower level	2011	21,929	1,462	20	1,462		21,199	10
11	North hall flooring	2011	11,519	768	20	768		11,136	11
12	Updated Outside leasehold courtyard- benches,garden	2011	12,571	838	10	838		12,151	12
13	Updated and replaced Roof & gutters	2011	80,797	5,386	10	5,386		78,099	13
14	Updated South hall bathroom-Flooring,door,windows	2011	16,442	1,096	20	1,096		15,893	14
15	Dialysis project retrofit room	2011	25,000	1,667	15	1,667		24,170	15
16	Ozone unit for washing machines	2011	17,000	1,133	10	1,133		16,430	16
17	Water softener	2011	10,939	729	20	729		10,572	17
18	Water heater system installed including plumbing and piping	2011	41,466	2,764	15	2,764		40,080	18
19									19
20	Labor & Repair to Heating Units	2012	4,875	325	15	325		4,387	20
21	North & Center Hall:Labor, paint, flooring, wallpaper, etc.	2012	26,712	1,781	15	1,781		24,043	21
22	Dialysis Unit Remodel: Labor, flooring, paint, electrical, etc.	2012	168,368	11,225	15	11,225		151,536	22
23	West Hall: Plumbing, bathroom fixtures, electrical,	2012	49,521	3,301	15	3,301		44,565	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		18,868	26
27	Updated West Hall: ceiling, flooring, electric, paint & labor	2013	45,448	3,032	15	3,032		33,721	27
28	West Hall - Project	2013	20,208	1,345	15	1,345		14,971	28
29	South Shower Rooms Update:Labor,tile,grab bars,plumbing	2013	13,289	886	15	886		9,855	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		10,801	31
32	West Hall Improvements: ceiling, bathrooms, electric, paint,	2013	8,182	118	15		(118)	8,182	32
33	wallpaper, wood, trim, handrails, baseboards, etc.								33
34	TOTAL (lines 1 thru 33)		\$ 3,212,920	\$ 97,514		\$ 71,135	\$ (26,379)	\$ 3,142,614	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:

01/01/2025

Ending:

12/31/2025

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 12E, Carried Forward		\$ 3,212,920	\$ 97,514		\$ 71,135	\$ (26,379)	\$ 3,142,614	1
2	Updated Center Hall	2014	16,330	1,089	15	1,089		12,523	2
3	- electric, paper, paint, misc								3
4	- flooring								4
5	Updated general heating	2014	31,193	2,080	15	2,080		23,919	5
6	- Equipment (units for heating)								6
7	- Misc (supplies)								7
8	Updated general upstairs	2014	33,945	2,263	15	2,263		26,025	8
9	- electric, paper, paint, misc								9
10	- flooring								10
11	Updated outside of building	2014	9,217	614	15	614		7,062	11
12	- court yard and entrance								12
13	Roof repair	2014	14,770	985	10	985		13,542	13
14									14
15	Roof - North Hall	2015	19,636	1,309	10	1,309		16,037	15
16	Updated Lower Level, Resident Dining Room	2015	32,842	2,189	15	2,189		22,985	16
17	- electric, paper, paint, misc								17
18	- flooring								18
19	Updated General upstairs, Main Lounge	2015	7,747	516	15	516		5,418	19
20	- electric, paper, paint, misc								20
21									21
22	Lounge - A/C Outside Unit	2018	16,093		15	1,073	1,073	8,046	22
23									23
24	Furnish & Install TPO Membrane Roof System - Roof (North hall	2019	70,800	4,720	15	4,720		31,073	24
25	R/M: Furnish & Install 8 ton A/C Unit - West Wing (Lounge)	2019	17,939		15	1,198	1,198	7,783	25
26	Disallowed portion due to outpatient therapy								26
27	A/C unit for Center Hall	2020	19,262	1,926	15	1,284	(642)	7,063	27
28	A/C unit lower level	2020	11,965	1,197	15	798	(399)	4,387	28
29	Upgrade Fire Alarm in Main Facility	2020	21,414	714	15	1,428	714	7,852	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,536,073	\$ 117,116		\$ 92,680	\$ (24,436)	\$ 3,336,329	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:

01/01/2025

Ending:

12/31/2025

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	\$ 117,116		\$ 92,680	\$ (24,436)	\$ 3,336,329	1
2	Therapy building improvement								2
3	Demo & Construction	2020	52,744	2,051	15	3,516	1,465	19,632	3
4	Ceiling, paint, misc	2020	27,636	1,075	15	1,842	767	10,287	4
5	Electrical	2020	23,885	929	15	1,592	663	8,890	5
6	Plumbing, flooring, entrance	2020	23,044	896	15	1,536	640	8,577	6
7									7
8	South Wing - Roof Repair	2021	32,562	2,171	15	2,171		9,769	8
9	South Wing Renovation - Plumbing, electrical, showers, heating &	2021	369,340	24,623	15	24,623		110,802	9
10	cooling, flooring, ceiling, doors and paint (Paid for with Stimulus								10
11	Funds)								11
12									12
13	Court yard entrance signs	2025	7,777	259	15	259		259	13
14	South Hall floors	2025	2,726	91	15	91		91	14
15									15
16									16
17									17
18									18
19	To reconcile to financial statements			(149,211)			149,211		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)		\$ 4,075,786	\$		\$ 128,311	\$ 128,311	\$ 3,504,638	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	684,127					684,127	73
74								74
75	TOTALS	\$ 684,127	\$	\$	\$		\$ 684,127	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				5	389,486	78
79										79
80	TOTALS			\$ 389,486	\$	\$	\$		\$ 389,486	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)	\$ 5,152,447	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 128,311	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 128,311	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,578,251	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:12/31/2025

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	-	-	-		15,506
Maintenance	Snowplow for dodge truck	2009	4,000	-	-	-		4,000
Maintenance	Trailer	2010	5,358	-	-	-		5,358
Maintenance	Dodge Truck	2011	39,797	-	-	-		39,797
Administrative	Dodge Van	2011	29,688	-	-	-		29,688
Maintenance	Snow Plow & Salt Spreader	2011	5,525	-	-	-		5,525
Maintenance	Kubuta Mower	2012	13,476	-	-	-		13,476
Maintenance	M&W Industrial - Forklift	2012	7,495	-	-	-	5	7,495
Administrative	Kubota RTV	2013	27,729	-	-	-	5	27,729
Facility	Sunset van	2017	34,181	-	-	-	5	34,181
Maintenance	Jeep Wrangler Rubicon	2019	101,231	-	-	-	5	101,231
Administrative	BMW X4	2019	68,921	-	-	-	5	68,921
Administrative	Subaru Forestar	2019	36,579	-	-	-	5	36,579
						-		
TOTAL			389,486	-	-	-		389,486

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: \$ 13,397 Description: Nursing 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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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	\$	680	\$ 48,974	\$	680	\$ 48,974	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		132	9,488		132	9,488	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		1,981	59,492		1,981	59,492	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				50,447		50,447	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See Sch 16A</u>	39(2)					26,299		26,299	12
13	Other (specify): <u></u>									13
14	TOTAL			\$	2,793	\$ 117,954	\$ 76,746	2,793	\$ 194,700	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: 12/31/2025

Schedule 19A

	Description	Amount
50020-40-4027	MEDICAL:In - House Expenses:Oxygen	17,067
50020-63-5400	MEDICAL:VA:Doctor visits	-
50020-56-5621	THERAPY:Equipment Purchases	-
50021-32-4035	MEDICAL:Medicare A	-
50020-30-4026	MEDICAL:Private:Resident Purchase	2,401
50021-31-0000	MEDICAL:Medicaid / IPAC:Medicaid Non Covered Meds	1,950
50021-31-4031	MEDICAL:Medicaid / IPAC:Non Covered Meds	-
50024-31-4222	MEDICAL:Medicaid / IPAC:Bundles Services	1,900
50024-30-4222	MEDICAL:Private:Bundled Services	(30)
50024-36-4222	MEDICAL:VA:Bundled Services	2,414
50020-56-5620	THERAPY:Supplies	597
	Total	26,299

XV. BALANCE SHEET - Unrestricted Operating Fund.

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	\$ 13,158	\$ 26,467	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -)	988,560	1,085,647	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Sch 17A	179,042	179,042	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,180,760	\$ 1,291,156	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	34,947	646,817	14
15	Leasehold Improvements, at Historical Cost	3,442,014	3,428,969	15
16	Equipment, at Historical Cost	1,253,712	1,073,613	16
17	Accumulated Depreciation (book methods)	(2,887,811)	(4,578,251)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,842,862	\$ 574,196	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,023,622	\$ 1,865,352	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 201,775	\$ 201,775	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,996	68,996	30
31	Accrued Taxes Payable (excluding real estate taxes)	(65,807)	(65,807)	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	453	453	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 267,417	\$ 267,417	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,032,865	2,419,909	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan from stockholders		500	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,032,865	\$ 2,420,409	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,300,282	\$ 2,687,826	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,723,340	\$ (822,474)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,023,622	\$ 1,865,352	48

*(See instructions.)

Facility Name: Medina Nursing Center
IDPH License ID Number: 0011551
Fiscal Year End: 12/31/2025

Schedule 17A

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

Description	Operating	After Consolidation
Quickbooks tax Holding Account	2,481	2,481
Solutions Payroll & Taxes 2418	156,940	156,940
Employee Advances account:Employee Uniform purchas	(6,145)	(6,145)
Employee Advances	453	453
Due From Accounts:Note due from CNA First	24,708	24,708
Due From Accounts:Due to / From apartments	605	605
Total - Line 9	179,042	179,042
	-	-

Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Direct Deposit Payable 1	(3,546)	(3,546)
Direct Deposit Payable 2	3,546	3,546
Repayment:Employee advance	(453)	(453)
Total - Line 36	(453)	(453)
	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,757,680	1
2	Restatements (describe):		2
3	Prior period adjustment	(94,462)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,663,218	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	60,122	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)	\$ 60,122	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)	\$ 1,723,340	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Medina Nursing Center

0011551

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 5,720,902	1
2	Discounts and Allowances for all Levels	(701,047)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,019,855	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	887,679	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 887,679	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	2,946	13
14	Non-Patient Meals	1,025	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(7,552)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,520	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 11,939	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	184	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 184	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	53,999	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 53,999	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,973,656	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,262,262	31
32	Health Care	2,664,738	32
33	General Administration	1,156,223	33
	B. Capital Expense		
34	Ownership	263,474	34
	C. Ancillary Expense		
35	Special Cost Centers	341,849	35
36	Provider Participation Fee	224,988	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,913,534	40
41	Income before Income Taxes (line 30 minus line 40)**	60,122	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 60,122	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 408,020	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,712,748	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,011,694	48
49	Medicare Part A	-195,406	49
50	Other-(specify) <u>Veterans Assistance</u>	2,082,800	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,019,855	56

Facility Name:

Medina Nursing Center

IDPH License ID Number:

0011551

Fiscal Year End:

12/31/2025

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Miscellaneous	(5,709)
HOSPICE: Equipment Rental	(32,540)
Misc Sales: Therapy Building Rental Income	(8,750)
Misc Sales: Services	(7,000)
Medicaid / IPAC: Miscellaneous	-
Total - Line 28	(53,999)
Variance	-

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	2,255	2,371	\$ 119,467	\$ 50.39	1
2	Assistant Director of Nursing	1,867	2,051	69,669	33.97	2
3	Registered Nurses	7,609	9,252	347,441	37.55	3
4	Licensed Practical Nurses	2,336	2,684	95,593	35.62	4
5	CNAs & Orderlies	37,077	48,911	823,867	16.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,682	2,804	51,878	18.50	9
10	Activity Assistants	972	1,069	18,997	17.77	10
11	Social Service Workers	6,132	6,304	131,553	20.87	11
12	Dietician					12
13	Food Service Supervisor	2,086	2,101	61,289	29.17	13
14	Head Cook	5,000	5,340	120,925	22.65	14
15	Cook Helpers/Assistants	12,149	12,369	206,084	16.66	15
16	Dishwashers					16
17	Maintenance Workers	5,936	6,708	128,861	19.21	17
18	Housekeepers	8,165	8,829	133,613	15.13	18
19	Laundry	3,628	3,870	60,952	15.75	19
20	Administrator	3,829	3,829	110,900	28.96	20
21	Assistant Administrator	1,125	1,125	18,000	16.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,192	7,692	155,941	20.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	110,040	127,309	\$ 2,655,030 *	\$ 20.86	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	143	\$ 8,308	1(3)	35
36	Medical Director	Monthly	14,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	4,200	10(3)	38
39	Pharmacist Consultant	12	2,095	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	24	1,959	11(3)	44
45	Social Service Consultant	22	1,726	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	201	\$ 32,688		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	4,163	\$ 302,087	10(3)	50
51	Licensed Practical Nurses	2,408	149,556	10(3)	51
52	Certified Nurse Assistants/Aides	11,183	442,619	10(3)	52
53	TOTAL (lines 50 - 52)	17,754	\$ 894,262		53

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

** See instructions.

Facility Name: Medina Nursing Center
IDPH License ID Number: 0011551
Fiscal Year End: 12/31/2025

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
RSM US LLP	Accounting	15,120
Clark and Diffenderfer	Accounting	1,850
DUANE MORRIS LLP	Legal	28,848
PointClickCare Technologies Inc	Computer Services	26,424
Smartlinx Solutions LLC	Computer Services	14,083
Mosley Business	Computer Services	5
Inovalon Provider, Inc	Computer Services	13,827
CleverBridge	Computer Services	88
Total (agree to Schedule V, line 19, column 3)		100,245
Allocated from Management Company Legal Fees		18,000
Allocated from Management Company Professional Services		1,230
Less: Non-Allowable Legal Fees		(2,928)
Total (agree to Schedule V, line 19, column 8)		116,547

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>5,235</u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| | <u>5,235</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>2,882</u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| | <u>2,882</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|--------------------|
| <u>IL HEALTHCARE ASSOCIATION (IHCA)</u> | <u>8,117</u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| <u></u> | <u></u> |
| | <u>8,117</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 29,091 Line 10(2)
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 224,988
This amount is to be recorded on line 42 of Schedule V.
- (8) 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.

- (9) 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
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ No Has any meal income been offset against related costs? No Indicate the amount. \$
- (12) 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
- (13) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) 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.