		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

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 Facility ID Number: 0011551

Facility Name: Medina Nursing Center

Address: P.O. Box 538 (Number) Durand (City) 61024 (Zip Code)

County: Winnebago

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

IDPA ID Number: 366125769001

Date of Initial License for Current Owners: 05/18/65

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	Holgeir Oksnevad
	(Title)	Administrator
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	32,485	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	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	61	102	1,842	2,005	8
9	SNF/PED					9
10	ICF	17,709	7,473		25,182	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,770	7,575	1,842	27,187	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.69%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]
Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1965

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,842

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/02 Fiscal Year: 12/31/02

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	187,062	9,201	5,245	201,508		201,508		201,508			1
2	Food Purchase		173,963		173,963		173,963	(3,824)	170,139			2
3	Housekeeping	67,151	18,187		85,338		85,338		85,338			3
4	Laundry	63,484	9,844		73,328		73,328	(1,240)	72,088			4
5	Heat and Other Utilities			53,040	53,040		53,040		53,040			5
6	Maintenance	43,212	12,977	39,829	96,018		96,018		96,018			6
7	Other (specify):*											7
8	TOTAL General Services	360,909	224,172	98,114	683,195		683,195	(5,064)	678,131			8
	B. Health Care and Programs											
9	Medical Director			4,500	4,500		4,500		4,500			9
10	Nursing and Medical Records	831,418	54,305	333,384	1,219,107		1,219,107	1,240	1,220,347			10
10a	Therapy		1,052	91,558	92,610		92,610		92,610			10a
11	Activities	34,637	2,176	6,910	43,723		43,723		43,723			11
12	Social Services	54,668		5,474	60,142		60,142		60,142			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	920,723	57,533	441,826	1,420,082		1,420,082	1,240	1,421,322			16
	C. General Administration											
17	Administrative	147,286			147,286		147,286		147,286			17
18	Directors Fees											18
19	Professional Services			50,316	50,316		50,316	2,500	52,816			19
20	Dues, Fees, Subscriptions & Promotions			5,071	5,071		5,071		5,071			20
21	Clerical & General Office Expenses	56,971	28,706	10,692	96,369		96,369		96,369			21
22	Employee Benefits & Payroll Taxes			202,089	202,089		202,089		202,089			22
23	Inservice Training & Education			4,216	4,216		4,216		4,216			23
24	Travel and Seminar			23,074	23,074		23,074	(1,882)	21,192			24
25	Other Admin. Staff Transportation			4,291	4,291		4,291		4,291			25
26	Insurance-Prop.Liab.Malpractice			22,051	22,051		22,051		22,051			26
27	Other (specify):*											27
28	TOTAL General Administration	204,257	28,706	321,800	554,763		554,763	618	555,381			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,485,889	310,411	861,740	2,658,040		2,658,040	(3,206)	2,654,834			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Medina Nursing Center #0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			72,951	72,951		72,951	9,432	82,383			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,459	2,459		2,459	3,771	6,230			32
33	Real Estate Taxes			37,424	37,424		37,424		37,424			33
34	Rent-Facility & Grounds			36,000	36,000		36,000	(36,000)				34
35	Rent-Equipment & Vehicles			12,855	12,855		12,855		12,855			35
36	Other (specify):*											36
37	TOTAL Ownership			161,689	161,689		161,689	(22,797)	138,892			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,755	825	40,580		40,580		40,580			39
40	Barber and Beauty Shops	10,058	272		10,330		10,330		10,330			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,727	48,727		48,727		48,727			42
43	Other (specify):* Nonallowable Costs			28,416	28,416		28,416	(28,416)				43
44	TOTAL Special Cost Centers	10,058	40,027	77,968	128,053		128,053	(28,416)	99,637			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,495,947	350,438	1,101,397	2,947,782		2,947,782	(54,419)	2,893,363			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,824)	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	(10,574)	30		9
10	Interest and Other Investment Income	(2,029)	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	(3,179)	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	(5,599)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,000)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(19,520)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,725)		$	30

OHF 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)	(7,694)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (7,694)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (54,419)		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	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center, Inc.
Provider # 0011551
December 31, 2002

Schedule 5A

Schedule VI.- Adjustment Detail
Line 29, Other Non-Allowable Expenses

Description	Amount	Sch V line reference
To DisallowVending Machine Supply	(8,904)	43
To Disallow Laboratory Expense	(684)	43
To Disallow Radiology Expense	(446)	43
To Disallow Insurance	(7,604)	43
To Disallow Travel & Seminar Expense	(1,882)	24
	(19,520)	

See Accountants' Compilation Report

STATE OF ILLINOIS

Medina Nursing Center

ID# 0011551

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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				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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,824)	0	0	0	0	0	0	0	0	0	0	(3,824)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,824)	0	0	0	0	0	0	0	0	0	0	(3,824)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,500	0	0	0	0	0	0	0	0	0	2,500	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	2,500	0	0	0	0	0	0	0	0	0	2,500	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,824)	2,500	0	0	0	0	0	0	0	0	0	(1,324)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(10,574)	20,006	0	0	0	0	0	0	0	0	0	9,432	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,029)	5,800	0	0	0	0	0	0	0	0	0	3,771	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(36,000)	0	0	0	0	0	0	0	0	0	(36,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,603)	(10,194)	0	0	0	0	0	0	0	0	0	(22,797)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(10,778)	0	0	0	0	0	0	0	0	0	0	(10,778)	43
44	**TOTAL Special Cost Centers**	(10,778)	0	0	0	0	0	0	0	0	0	0	(10,778)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(27,205)	(7,694)	0	0	0	0	0	0	0	0	0	(34,899)	45

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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 %			Medina Manor Building, Inc.	Durand	Lessor
				- Owner Johs Oksnevad is the father of Holgeir Oksnevad.		

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting Fees	$	Medina Manor Building, Inc.	0.00%	$ 2,500	$ 2,500	1
2	V	30	Depreciation		Medina Manor Building, Inc.	0.00%	20,006	20,006	2
3	V	32	Interest		Medina Manor Building, Inc.	0.00%	5,800	5,800	3
4	V	34	Rent Income	36,000	Medina Manor Building, Inc.	0.00%		(36,000)	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			$ 36,000			$ 28,306	$ * (7,694)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Holgeir Oksnevad	President	Administrator	100.00	None	55	100.00	Salary	$ 147,286	L17, C1	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	$ 147,286		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10					N/A					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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	State Bank of Davis		X	Bus Loan	$816.00	06/15/98	$ 40,200	$ 4,783	06/15/03	0.0825	$ 2,459	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Medina Manor Building	X		Working Capital	None	various	various	33,958	Demand	0.0700	5,800	6
7	Durand State Bank		X	Working Capital	None	12/31/02	50,060	17,000	03/31/03	0.0675		7
8	State Bank of Davis		X	Line of Credit	None	2/28/2002	150,000	116,114	4/30/2003	0.0675		8
9	TOTAL Facility Related				$816.00		$ 240,260	$ 171,855			$ 8,259	9
	B. Non-Facility Related*											
10								Interest Income Offset			(2,029)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,029)	14
15	TOTALS (line 9+line14)						$ 240,260	$ 171,855			$ 6,230	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 2001 report.		$ 37,000	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.)	2001	$ 36,424	2
3. Under or (over) accrual (line 2 minus line 1).		$ (576)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,000	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.		$ 37,424	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	33,224	8
	1998	32,672	9
	1999	31,868	10
	2000	35,002	11
	2001	36,424	12

2002 Estimated Tax	36,424
Estimated Tax Increase	1.05
	38,245
Use	38,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Medina Nursing Center COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0011551

CONTACT PERSON REGARDING THIS REPORT Charles J. Fischer

TELEPHONE (312) 634-4580 FAX #: (312) 634-5518

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-15-251-001	Medina Manor Building	$ 759.18	$ 759.18
2.	05-15-251-002	Medina Manor Building	$ 34,888.70	$ 34,888.70
3.	05-15-251-003	Medina Manor Building	$ 775.86	$ 775.86
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,423.74	$ 36,423.74

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 direct used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

Medina Manor Apartments
-Retirement Apartments
-22 units
-20,000 Sq. ft

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	7 acres	1965	$ 3,048	1
2					2
3	TOTALS			$ 3,048	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1965	1965	$ 488,644	$	30	$	$	$ 488,644	4
5	25		1980	1980	158,173		30	5,272	5,272	121,417	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	103	20	155	52	2,709	22
23	Building Improvements			1986	17,543		10			17,543	23
24	Building Improvements			1987	56,373		20	2,819	2,819	43,685	24
25	Building Improvements			1988	14,212	950	20	711	(239)	10,302	25
26	Building Improvements			1989	30,063	2,004	20	1,503	(501)	20,292	26
27	Building Improvements			1990	1,601	107	20	80	(27)	1,004	27
28	Building Improvements			1991	51,619	3,441	20	2,581	(860)	29,681	28
29	Building Improvements			1991	11,626		20	581	581	6,103	29
30	Building Improvements			1992	39,070	2,605	20	1,954	(651)	18,561	30
31	Building Improvements			1992	3,295	203	20	165	(38)	1,730	31
32	Building Improvements			1992	19,372		20	969	969	10,172	32
33	Building Improvements			1992	23,809	2,362	20	1,190	(1,172)	12,495	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements	1993	$ 37,059	$ 2,471	20	$ 1,853	$ (618)	$ 17,606	37
38	Building Improvements	1993	100,000		20	5,000	5,000	46,669	38
39	Building Improvements	1994	53,900	3,216	20	2,695	(521)	22,909	39
40	Building Improvements	1994	15,610		10	1,561	1,561	13,269	40
41	Building Improvements	1995	47,826	3,188	15	3,188		23,911	41
42	Building Improvements	1995	36,144	2,410	15	2,410		18,074	42
43	Outdoor Signs	1996	2,149	143	15	143		930	43
44	Backflow Preventors	1996	3,679	245	15	245		1,593	44
45	Garbage Disposal	1996	761	51	15	51		331	45
46	Custom Therapy Cabinets	1997	2,532	169	15	169		929	46
47	Door	1997	1,996	133	15	133		732	47
48	Sign	1997	666	44	15	44		243	48
49	Air Conditioner	1997	3,500	233	15	233		1,282	49
50	Lights	1997	621	41	15	41		226	50
51	Driveway	1997	2,875	192	15	192		1,056	51
52	Fire Alarm	1997	1,246	83	15	83		457	52
53	Plumbing	1997	5,122	341	15	341		1,876	53
54	Telephone System	1997	1,152	77	15	77		399	54
55	Permanent Outdoor Receptacles	1997	585	39	15	39		215	55
56	Office Remodeling	1998	2,454	164	15	164		738	56
57	Exterior Doors	1998	7,652	510	15	510		2,295	57
58	Windows	1998	15,536	1,036	15	1,036		4,662	58
59	Roof Repair	1998	2,317	154	15	154		693	59
60	Water and Sewer Improvements	1998	3,165	211	15	211		948	60
61	Fire Alarm	1998	1,157	77	15	77		347	61
62	Telephone System	1998	1,467	98	15	98		439	62
63	Time Clock System	1998	8,238	549	15	549		2,472	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,350,158	$ 27,650		$ 39,277	$ 11,627	$ 1,021,897	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,350,158	$ 27,650		$ 39,277	$ 11,627	$ 1,021,897	1
2	Blinds	1999	3,689	246	15	246		859	2
3	Window Replacement	1999	5,145	305	15	343	38	1,201	3
4	Rewire & Replumb Laundry Room	1999	7,824	481	15	521	40	1,824	4
5	Floor Tile	1999	1,049	70	15	70		245	5
6	Air Conditioning	1999	1,895	126	15	126		441	6
7	Boiler	1999	535	35	15	35		123	7
8	Sidewalk	2000	1,386	92	15	92		230	8
9	Kickplates	2000	608	40	15	40		100	9
10	Landscaping Brick	2000	1,139	76	15	76		190	10
11	Blacktop Parking Lot	2001	15,000	1,000	15	1,000		1,500	11
12	Dumpster Gate Frames	2001	1,650	110	15	110		165	12
13	Dumpster Concrete Platform	2001	3,700	247	15	247		370	13
14	Stone Wall	2001	1,665	111	15	111		166	14
15	Video Surveillance	2002	14,865	496	15	496		496	15
16	Wrought Iron Fence	2002	5,105	170	15	170		170	16
17	Nurses Call System	2002	12,726	424	15	424		424	17
18	Custom Doors	2002	9,427	314	15	314		314	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,437,566	$ 31,993		$ 43,698	$ 11,705	$ 1,030,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 182,353	$ 21,341	$ 19,068	$ (2,273)	10 Years	$ 126,345	71
72	Current Year Purchases	38,110	1,948	1,948		10 Years	1,948	72
73	Fully Depreciated Assets	12,502					12,502	73
74								74
75	TOTALS	$ 232,965	$ 23,289	$ 21,016	$ (2,273)		$ 140,795	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Activity Bus	1975 Ford Bus	1985	$ 9,409	$	$	$	3	$ 9,409	76
77	Resident Van	1991 Chevy Lumina	1991	18,008				3	18,008	77
78	Activity Bus	1998 Ford Bus	1998	49,705	4,971	4,971		5	49,705	78
79	From Page 13A			57,763	12,698	12,698		5	15,259	79
80	TOTALS			$ 134,885	$ 17,669	$ 17,669	$		$ 92,381	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)	$ 1,808,464	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 72,951	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 82,383	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,432	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,263,891	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$	$	$	$ 0		$	71
72	Current Year Purchases				0			72
73	Fully Depreciated Assets				0			73
74					0			74
75	TOTALS	$ 0	$ 0	$ 0	$ 0		$ 0	75

D. Vehicle Depreciation (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	Maintenance	1997 Dodge Pickup	2000	$ 23,705	$ 9,292	$ 9,292	$ 0	5	11,853	76
77	Administrative	2002 Jeep Liberty	2002	30,000	3,000	3,000	0	5	3,000	77
78	Administrative	2000 Dodge Caravan	2002	4,058	406	406	0		406	78
79							0			79
80	TOTALS			$ 57,763	$ 12,698	$ 12,698	$ 0		$ 15,259	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)	$	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)	$	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5					N/A			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 . N/A N/A

9. Option to Buy: [ ] YES [ ] NO Terms: N/A *

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.	/2003	$
13.	/2004	$
14.	/2005	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO
16. Rental Amount for movable equipment: $ N/A Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2000 BMW	$ 984.97	$ 12,855	17
18					18
19					19
20					20
21	TOTAL		$ 984.97	$ 12,855	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

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

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] 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 AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

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	Nurse Aide 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 aides from other facilities.

$

D. NUMBER OF AIDES 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 aide 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 aides.
(e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	L10A, C3	hrs	$	1,381	$ 42,812	$	1,381	$ 42,812	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		174	5,209		174	5,209	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C2 & C3	hrs		887	43,537	1,052	887	44,589	4
5	Physician Care		visits							5
6	Dental Care	L39, C3	visits				825		825	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				39,755		39,755	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	2,442	$ 91,558	$ 41,632	2,442	$ 133,190	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center
Provider #: 0011551
01/01/02 to 12/31/02

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,072	$ 4,326	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	551,224	551,224	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,983	43,983	6
7	Other Prepaid Expenses	40,033	41,267	7
8	Accounts Receivable (owners or related parties)	14,000	14,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 653,312	$ 654,800	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,048	13
14	Buildings, at Historical Cost		646,816	14
15	Leasehold Improvements, at Historical Cost	580,633	790,750	15
16	Equipment, at Historical Cost	517,447	367,850	16
17	Accumulated Depreciation (book methods)	(714,017)	(1,263,891)	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): Life Insurance Cash Value	28,399	28,399	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 412,462	$ 572,972	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,065,774	$ 1,227,772	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (11,620)	$ (11,620)	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	46,243	46,243	28
29	Short-Term Notes Payable		33,958	29
30	Accrued Salaries Payable	84,185	84,185	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,000	38,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	3,107	3,107	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 159,915	$ 193,873	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	137,897	137,897	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)**	$ 137,897	$ 137,897	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 297,812	$ 331,770	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 767,962	$ 896,002	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,065,774	$ 1,227,772	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Medina Nursing Center, Inc.
Provider # 0011551
December 31, 2002

Page 17 **Schedule 17A**
Schedule XV.
Balance Sheet

Line 36 - Other Current Liabilities

	Operating	After Consolidation
Miscellaneous Current Liabilites	12	12
Due to Related Party	3,095	3,095
Total	3,107	3,107

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 631,116	1
2	Restatements (describe):		2
3	**Rounding Adjustment**	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 631,115	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	173,847	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	(37,000)	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)**	$ 136,847	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)**	$ 767,962	24 *

Operating Entity Only
*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,727,635	1
2	Discounts and Allowances for all Levels	99,566	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,827,201	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	161,209	6
7	Oxygen	3,609	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 164,818	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,651	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,377	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,368	19
20	Radiology and X-Ray	526	20
21	Other Medical Services	47,413	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 106,335	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,029	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,029	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Schedule 19A	21,246	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 21,246	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,121,629	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	683,195	31
32	Health Care	1,420,082	32
33	General Administration	554,763	33
	B. Capital Expense		
34	Ownership	161,689	34
	C. Ancillary Expense		
35	Special Cost Centers	79,326	35
36	Provider Participation Fee	48,727	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,947,782	40
41	**Income before Income Taxes (line 30 minus line 40)****	173,847	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 173,847	43

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

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

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

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

Medina Nursing Center, Inc.
Provider # 0011551
12/31/2002

Schedule 19A

Schedule XVII
Income Statement

Line 28a - Other Revenue (specify):

	Amount
Vending Machine Income	9,281
Uniform Income	1,650
Food Purchased	3,824
Meal Sales	4,026
Miscellaneous Income	2,465
Total	21,246

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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	2,024	2,080	$ 46,675	$ 22.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,098	4,531	90,979	20.08	3
4	Licensed Practical Nurses	9,767	10,250	166,144	16.21	4
5	Nurse Aides & Orderlies	45,636	47,618	451,724	9.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,816	1,968	18,881	9.59	9
10	Activity Assistants	2,043	2,187	15,756	7.20	10
11	Social Service Workers	4,107	4,325	54,668	12.64	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	27,041	13.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,193	21,402	160,021	7.48	15
16	Dishwashers					16
17	Maintenance Workers	4,689	4,908	43,212	8.80	17
18	Housekeepers	6,811	7,478	67,151	8.98	18
19	Laundry	7,673	8,257	63,484	7.69	19
20	Administrator	2,860	2,860	147,286	51.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,570	4,704	56,971	12.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,628	1,773	16,384	9.24	31
32	Other Health Ca Care Plan Coord	2,517	2,687	59,512	22.15	32
33	Other(specify) Barber & Beauty	1,005	1,098	10,058	9.16	33
34	TOTAL (lines 1 - 33)	123,397	130,206	$ 1,495,947 *	$ 11.49	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	105	$ 5,245	L1, C3	35
36	Medical Director	Monthly	4,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	17	1,310	L10, C3	38
39	Pharmacist Consultant	Monthly	569	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	260	L11, C3	44
45	Social Service Consultant	35	2,470	L12, C3	45
46	Other(specify)				46
47	Physical Rehab Consulting	27	1,338	L10, C3	47
48	Occupational Rehab Consulting	22	1,075	L10, C3	48
49	TOTAL (lines 35 - 48)	210	$ 16,767		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	579	$ 22,300	L10, C3	50
51	Licensed Practical Nurses	2,424	76,193	L10, C3	51
52	Nurse Aides	11,696	230,599	L10, C3	52
53	TOTAL (lines 50 - 52)	14,699	$ 329,092		53

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Holgeir Oksnevad	Administrator	100%	$ 147,286
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 147,286

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser LLP	Accounting	$ 18,039
American Express Tax & Business Services	Accounting	4,366
Duane, Morris, & Heckscher	Legal	8,601
Achieve Software	Computer	4,949
Mutual of Omaha	Computer	118
Main St. Web Design	Computer	500
Information Control	Computer	1,174
Business Management	Computer	11,156
First USA Bank (Comp USA)	Computer	853
Diana Lyons Office Help	Office Help	492
Nicole Palmer	Office Help	68
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 50,316

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,471
Unemployment Compensation Insurance	11,058
FICA Taxes	108,689
Employee Health Insurance	30,741
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physical	6,175
401(K) Plan	5,169
Other Health Insurance	3,799
Employee Goodwill	4,612
Uniforms	3,375
TOTAL (agree to Schedule V, line 22, col.8)	$ 202,089

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

Description	Line #	Amount
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	2,272
Health Care Worker Background Check (Indicate # of checks performed 63)	756
Illinois Health Care Association	135
Secretary of State	480
Miscellaneous Dues and Subscriptions	1,006
Miscellaneous License and Fees	222
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,071

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,149
Seminar Expense	17,043
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,192

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Medina Nursing Center
Provider #: 0011551
01/01/02 to 12/31/02

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	50,316
Allocated from Related Party	
Altschuler, Melvoin & Glasser LLP	2,500
Total (agree to Schedule V, line 19, column 8)	52,816

See Accountants' Compilation Report

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9								N/A					
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Medina Nursing Center # 0011551 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $135**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **1,240** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **48,727**
This amount is to be recorded on line 42 of Schedule V.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **3,824**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain.

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

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Medina Nursing Center** **03:38 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-54,419	equal to	-54,419	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	6,230	equal to	6,230	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	37,424	equal to	37,424	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	82,383	equal to	82,383	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	12,855	equal to	12,855	0	FAILED	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	92,610	equal to	92,610	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	41,632	equal to	40,807	825	FAILED	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	683,195	equal to	683,195	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,420,082	equal to	1,420,082	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	554,763	equal to	554,763	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	161,689	equal to	161,689	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	79,326	equal to	79,326	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	48,727	equal to	48,727	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	771,906	equal to	831,418	-59,512	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	34,637	equal to	34,637	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	54,668	equal to	54,668	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	187,062	equal to	187,062	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	43,212	equal to	43,212	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	67,151	equal to	67,151	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	63,484	equal to	63,484	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	147,286	equal to	147,286	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	56,971	equal to	56,971	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,495,947	equal to	1,495,947	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,245	< or = to	5,245	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,500	< or = to	4,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	330,971	< or = to	333,384	-2,413	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	260	< or = to	6,910	-6,650	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,470	< or = to	5,474	-3,004	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	147,286	equal to	147,286	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	50,316	equal to	50,316	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	202,089	equal to	202,089	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,071	equal to	5,071	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	21,192	equal to	21,192	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	48,727	equal to	48,727	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,842	equal to	1,842	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-7,694	equal to	-7,694	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	171,855	equal to	171,855	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	38,000	equal to	38,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	3,048	equal to	3,048	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,437,566	equal to	1,437,566	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	367,850	equal to	367,850	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,263,891	equal to	1,263,891	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	767,962	equal to	767,962	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	173,847	equal to	173,847	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,065,774	equal to	1,065,774	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	187,062	9,201	5,245	201,508	0	201,508	0	201,508
2. Food P	0	173,963	0	173,963	0	173,963	-3,824	170,139
3. Housek	67,151	18,187	0	85,338	0	85,338	0	85,338
4. Laundry	63,484	9,844	0	73,328	0	73,328	-1,240	72,088
5. Heat ar	0	0	53,040	53,040	0	53,040	0	53,040
6. Mainter	43,212	12,977	39,829	96,018	0	96,018	0	96,018
7. Other (	0	0	0	0	0	0	0	0
8. Total G	360,909	224,172	98,114	683,195	0	683,195	-5,064	678,131
9. Medical	0	0	4,500	4,500	0	4,500	0	4,500
10. Nursin	831,418	54,305	333,384	1,219,107	0	1,219,107	1,240	1,220,347
10a. Ther	0	1,052	91,558	92,610	0	92,610	0	92,610
11. Activit	34,637	2,176	6,910	43,723	0	43,723	0	43,723
12. Social	54,668	0	5,474	60,142	0	60,142	0	60,142
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	920,723	57,533	441,826	1,420,082	0	1,420,082	1,240	1,421,322
17. Admin	147,286	0	0	147,286	0	147,286	0	147,286
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	50,316	50,316	0	50,316	2,500	52,816
20. Fees,	0	0	5,071	5,071	0	5,071	0	5,071
21. Clerica	56,971	28,706	10,692	96,369	0	96,369	0	96,369
22. Emplo	0	0	202,089	202,089	0	202,089	0	202,089
23. Inserv	0	0	4,216	4,216	0	4,216	0	4,216
24. Travel	0	0	23,074	23,074	0	23,074	-1,882	21,192
25. Other	0	0	4,291	4,291	0	4,291	0	4,291
26. Insura	0	0	22,051	22,051	0	22,051	0	22,051
27. Other	0	0	0	0	0	0	0	0
28. Total (	204,257	28,706	321,800	554,763	0	554,763	618	555,381
29. Total (	1,485,889	310,411	861,740	2,658,040	0	2,658,040	-3,206	2,654,834
30. Depre	0	0	72,951	72,951	0	72,951	9,432	82,383
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	2,459	2,459	0	2,459	3,771	6,230
33. Real E	0	0	37,424	37,424	0	37,424	0	37,424
34. Rent -	0	0	36,000	36,000	0	36,000	-36,000	0
35. Rent -	0	0	12,855	12,855	0	12,855	0	12,855
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	161,689	161,689	0	161,689	-22,797	138,892
38. Medic	0	0	0	0	0	0	0	0
39. Ancilla	0	39,755	825	40,580	0	40,580	0	40,580
40. Barbe	10,058	272	0	10,330	0	10,330	0	10,330
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	48,727	48,727	0	48,727	0	48,727
43. Other	0	0	28,416	28,416	0	28,416	-28,416	0
44. Total S	10,058	40,027	77,968	128,053	0	128,053	-28,416	99,637
45. Grand	1,495,947	350,438	1,101,397	2,947,782	0	2,947,782	-54,419	2,893,363

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	4,072	4,326
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	551,224	551,224
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	43,983	43,983
7. Other Prepaid Expenses	40,033	41,267
8. Accounts Receivable-Owner/Related Party	14,000	14,000
9. Other (specify):	0	0
10. Total current assets	653,312	654,800
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	3,048
14. Buildings, at Historical Cost	0	646,816
15. Leasehold Improvements, Historical Cost	580,633	790,750
16. Equipment, at Historical Cost	517,447	367,850
17. Accumulated Depreciation (book methods)	-714,017	-1,263,891
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	28,399	28,399
24. Total Long-Term Assets	412,462	572,972
25. Total Assets	1,065,774	1,227,772
CURRENT LIABILITIES		
26. Accounts Payable	-11,620	-11,620
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	46,243	46,243
29. Short-Term Notes Payable	0	33,958
30. Accrued Salaries Payable	84,185	84,185
31. Accrued Taxes Payable		
32. Accrued Real Estate Taxes	38,000	38,000
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	3,107	3,107
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	159,915	193,873
LONG TERM LIABILITES		
39.Long-Term Notes Payable	137,897	137,897
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	137,897	137,897
46.Total Liabilities	297,812	331,770
47.Total Equity	767,962	896,002
48.Total Liabilities and Equity	1,065,774	1,227,772

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,727,635
2. Discounts and Allowances for all Levels	99,566
Subtotal - Inpatient Care	2,827,201
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	161,209
7. Oxygen	3,609
Subtotal - Anciliary Revenue	164,818
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	7,651
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	49,377
18. Sale of Supplies to Non-Patients	0
19. Laboratory	1,368
20. Radiologyand X-Ray	526
21. Other Medical Services	47,413
22. Laundry	0
Subtotal - Other Operating Revenue	106,335
24. Contributions	0
25. Interest and Other Investments Income	2,029
Subtotal - Non-Operating Revenue	2,029
27. Other Revenue (specify):	0
28. Other Revenue (specify):	21,246
Subtotal - Other Revenue	21,246
30. Total Revenue	3,121,629
31. General Services	683,195
32. Health Care	1,420,082
33. General Administration	554,763
34. Ownership	161,689
35. Special Cost Centers	79,326
35. Provider Participation Fee	48,727
37. Other	0
40. Total Expenses	2,947,782
41. Income Before Income Taxes	173,847
42. Income Taxes	0
43. Net Income or Loss for the Year	173,847

Page

1
2
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9 Line 16 for mortgage insurance.
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