

**WISCONSIN MEDICAID PROGRAM 2020 NURSING HOME COST REPORT****SCHEDULE 1: Facility & Preparer Information****SECTION A - FACILITY INFORMATION**

Facility Name Brown County Community Treatment Center		Main Telephone Number 920.391.4700	Main Email Address None	
Facility Street Address 3150 Gershwin Dr		City Green Bay	State WI	Zip Code 54311
Contact Person Donna Franke		Contact Telephone Number 920.391.4750	Contact Email Address donna.franke@browncountywi.gov	
Cost Report Period Start Date 1/1/2020	Cost Report Period End Date 12/31/2020	Medicaid Provider Number 20159800	National Provider Identifier (NPI) 1033214150	POP ID Number 171
Administrator Samantha Behling	Chief Financial Officer Eric Johnson (Finance Manager)	Where are the financial records of the nursing home located? In house		

**SECTION B - PREPARER OF THE REPORT IF NOT AN EMPLOYEE OF THE PROVIDER**

Name and Title			Telephone Number	
Address		City	State	Zip Code
SIGNATURE - Original Signature of Preparer			Date Signed	

**SECTION C - CERTIFICATION BY AN OFFICER OR ADMINISTRATOR OF THE NURSING HOME**

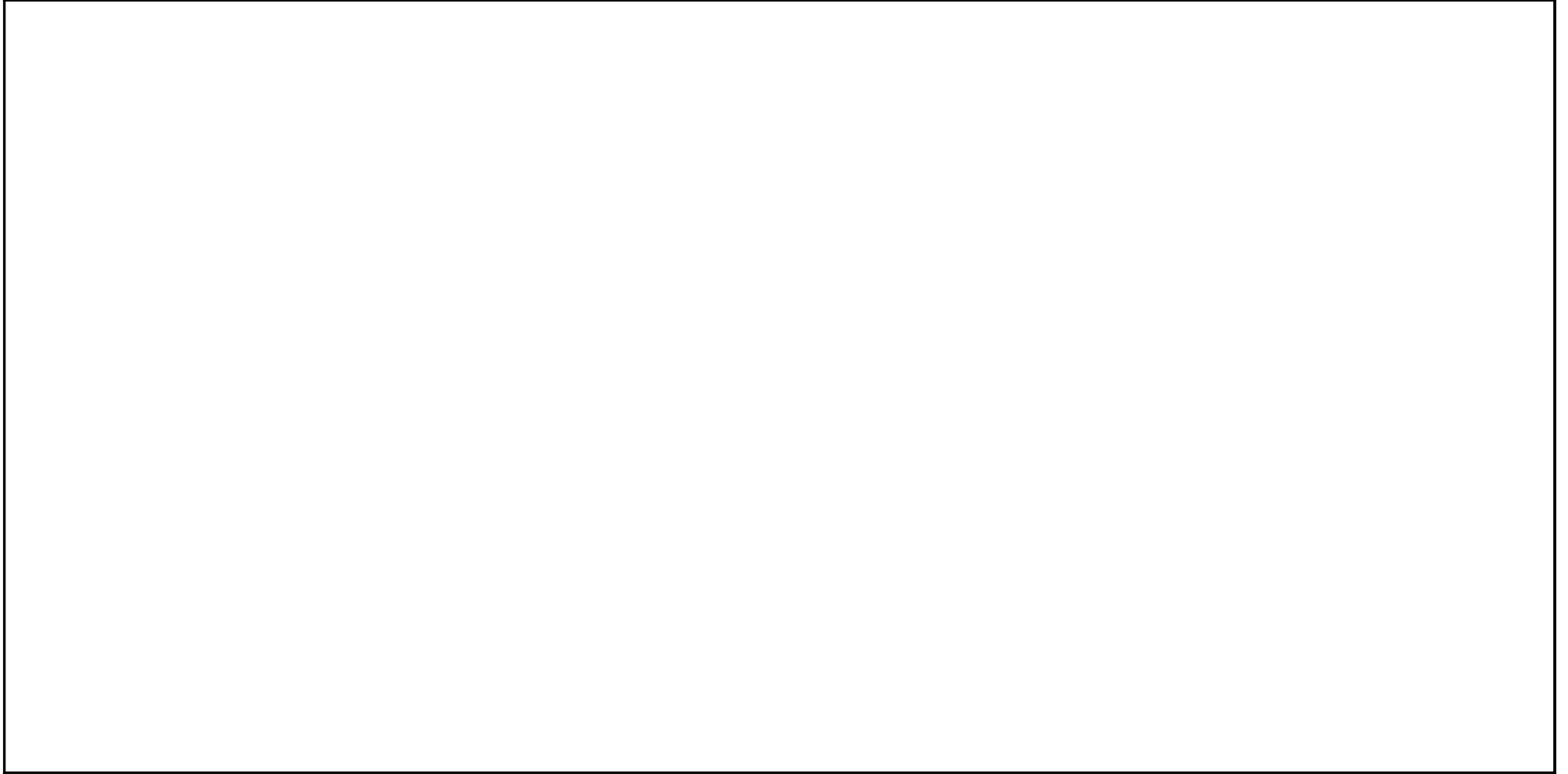
This certification must be signed and submitted before the information included in the cost report can be used to calculate Medicaid payment rates. Misrepresentation or falsification of any information contained in this report may be punishable by fine and/or imprisonment under state or federal law.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying report and any supporting schedules.

I HEREBY CERTIFY that to the best of my knowledge and belief, it is a true, correct, and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted in the report.

SIGNATURE - Original Signature of Officer or Administrator of Nursing Home		Title	Date Signed
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## SCHEDULE 2: Provider Notes

A large, empty rectangular box with a black border, intended for the provider to enter their notes. The box is currently blank.

### SCHEDULE 3: General Information

1. Type of Medicaid certification (check all that apply)  (01) Nursing Facility  (10) ICF-IID

2. Type of ownership (check one)  (1) Proprietary  (2) Voluntary Non-Profit  (3) Governmental

3. County of facility Brown County Code 5

4. Does the facility self-fund any of the fringe benefits reported on schedule 28? If yes, complete Schedule S-F FB.  (1) Yes  (2) No

5. Fiscal Year Beginning Month Jan Fiscal Year Ending Month Dec

6. List the number of licensed beds at the beginning and end of your cost reporting period. Do not include restricted beds.

	DATE	BEDS
<u>Beds at Beginning of Cost Reporting Period</u>	<u>1/1/2020</u>	<u>63</u>
If there has been a change in the number of licensed beds, list the date(s) of the change(s), the number of beds and briefly explain.	<u>12/31/2020</u>	<u>63</u>
<u>Beds at End of Cost Reporting Period</u>	<u>        </u>	<u>        </u>
<u>        </u>	<u>        </u>	<u>        </u>

7. Has a certified audit been conducted for the cost reporting period? If yes, submit complete report copy including notes to the financial statements.  (1) Yes  (2) No

8. Check all related party transaction types for which expenses are reported.  (1) Related party lease of building  (2) Compensation to owners/family relation  (3) Interest expense on related party loans  (4) Other related party transactions

9. A final adjusted trial balance for the cost reporting period, including a reconciliation of the trial balance to the cost report must be submitted with this cost report. Have copies been made and included with this cost report?  Yes  No

10. Asset depreciation schedules detailing amounts reported on Schedule 34 - Depreciation expenses must be submitted. Have copies been made and included with this cost report?  Yes  No

**11. Single occupancy rooms:** On the right side of the license effective on the last day of the cost report period, you will find the capacity of 1 BED, 2 BED, 3 BED, and 4 BED rooms. Add the number of beds labeled 1 BED and enter it in column C (Single-Bed Rooms). Add the number of beds on all other lines and enter it in column D (Beds in Multiple-Bed Rooms). Add the number of beds in single rooms (column C) to the number of beds in multiple-bed rooms (column D) and enter the total in Column E (Total Licensed Beds). This total must agree with the maximum capacity shown on your license. If your facility has more than one license, list each license on a separate line and total for each column.

	A. NAME	B. License Number	C. Single-Bed Rooms	D. Beds in Multiple-Bed Rooms	E. Total Licensed Beds
1.	<u>Brown County Bayshore Village</u>	<u>2405</u>	<u>63</u>	<u>-</u>	<u>63</u>
2.	<u>        </u>	<u>        </u>	<u>        </u>	<u>        </u>	<u>-</u>
3.	<u>        </u>	<u>        </u>	<u>        </u>	<u>        </u>	<u>-</u>
4.	<u>TOTAL .....</u>	<u>        </u>	<u>63</u>	<u>-</u>	<u>63</u>

**SCHEDULE 4: Shared Services**

Identify all major revenue generating activities with which the Medicaid nursing home provider is associated.	Check services shared with the nursing home							
	Nursing	Sp. Care	Dietary	Maint.	Hskg.	Laundry	A & G	Util.
1. Another Medicaid NH provider, Name of provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Hospital, Name of hospital: Nicolet Psychiatric Hospital Beds at end of cost report period: 16	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Non-Medicaid Nursing Home, Beds at end of cost report period:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Non-Medicaid CBRF, Beds at end of cost report period:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Apartment units, Beds at end of cost report period:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Room and Board - Other, Beds at end of cost report period:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Therapy services, Describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Laboratory or radiology services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Rental of building space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
11. Adult Day Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Home Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Food catering services (meals on wheels, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Other, Describe: CBRF Crisis	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
17. Any items checked in this column x = Yes blank = No	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**SCHEDULE 5 - NO LONGER USED**

**SCHEDULE 6: Total Patient Days**

	LEVEL OF CARE (LOC)		
	NON DD	DD	TOTAL
1a. Medicaid (T-19) . . . . .	15,831		15,831
1b. ICF-IID Medicaid (T-19) . . . . .			-
1c. Family Care (T-19) . . . . .			-
1d. Other Medicaid Managed Care (T-19) . . . . .	2,945		2,945
1e. Hospice (T-19) . . . . .	796		796
1f. Ventilator (T-19) . . . . .			-
2a. Medicare (T-18) . . . . .	322		322
2b. Medicare Advantage, for days covered as a Part A stay	-		-
3a. Private pay & Insurance . . . . .	1,598		1,598
3b. Medicare Advantage, for days not covered as a Part A stay	-		-
3c. Hospice (Private pay & Insurance)	-		-
4. Other, Specify: <u>Other Managed Care M</u>	164		164
5. TOTAL INHOUSE PATIENT DAYS . . . . .	21,656	-	21,656

<b>SECTION B - BED HOLD DAYS</b>			
<b>Charged Bed Hold Days Only</b>			
	NON DD	DD	TOTAL
6a. Medicaid (T-19) . . . . .	77		77
6b. ICF-IID Medicaid (T-19) . . . . .			-
6c. Family Care & Partnership (T-19) . . . . .			-
7. All Other . . . . .			-
8. TOTAL CHARGED BED HOLD DAYS . . . . .	77	-	77

<b>SECTION C - TOTAL PATIENT DAYS</b>			
	NON DD	DD	TOTAL
9. TOTAL DAYS . . . . .	21,733	-	21,733

**SCHEDULE 7 - NO LONGER USED**

**SCHEDULE 8: Medicaid Bedhold Eligibility**

1. MONTH . . . . .	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
2. Days in Month . . . . .	31	29	31	30	31	30	31	31	30	31	30	31	366
3. Licensed Beds for Bed Hold Testing . . . . .	63	63	63	63	63	63	63	63	63	63	63	63	756
4. Occupancy Test: Row 2 x (Row 3 x 94%)	1,836	1,717	1,836	1,777	1,836	1,777	1,836	1,836	1,777	1,836	1,777	1,836	21,677
5. Inhouse patient days	1,934	1,788	1,910	1,862	1,939	1,849	1,778	1,776	1,746	1,768	1,660	1,646	21,656
6. Bed Hold days . . . . .	11	16	7	-	-	4	39	-	-	-	-	-	77
7. TOTAL DAYS . . . . .	1,945	1,804	1,917	1,862	1,939	1,853	1,817	1,776	1,746	1,768	1,660	1,646	21,733
	n/a	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail	Fail	Fail	Fail	

Explanation for why Licensed Beds for Bed Hold Testing are less than Licensed Beds: \_\_\_\_\_

NOTE: If "Occupancy Test" on line 4 is greater than the "Total Days" on Line 7, bed hold should not be billed in the following month.

**SCHEDULE 9 - NO LONGER USED**

**SCHEDULE 10: Balance Sheet**

ASSETS		Begin Date 1/1/20	End Date 12/31/20	LIABILITIES AND OWNERS' EQUITY		Begin Date 1/1/20	End Date 12/31/20	
CURRENT ASSETS	Cash on hand and in bank . . . . .	\$1,030	\$922,414	CURRENT LIABILITIES	Notes and loans payable, list below:			
	Temporary investments . . . . .	-	-					
	Resident accounts receivable . . . . .	1,313,215	787,921					
	Other accounts receivable . . . . .	3,371,940	3,412,318					
	Due from related parties . . . . .	-	-					
	Notes receivable . . . . .	-	-			Due to related parties . . . . .	894,365	194,203
	Accrued interest receivable . . . . .	-	-			Accounts payable . . . . .	200,199	-
	Inventories . . . . .	45,166	51,863			Accrued salaries . . . . .		
	Prepaid expenses . . . . .	83,273	92,125			Other accrued expenses . . . . .		
	Resident funds held in trust . . . . .					Resident trust funds payable . . . . .		
Other current assets, list below:				Other current liabilities . . . . .	279,595	230,530		
				TOTAL CURRENT LIABILITIES . . . . .	\$1,374,159	\$424,733		
				LONG TERM LIAB.	Notes and loans payable (list) below:			
TOTAL CURRENT ASSETS . . . . .	\$4,814,624	\$5,266,641						
PROPERTY, PLANT, EQUIP.	Land . . . . .	\$8,509	\$8,509		Other long term liabilities . . . . .	7,210,251	7,900,776	
	Land improvements . . . . .	689,247	689,247		TOTAL LONG TERM LIABILITIES . . . . .	\$7,210,251	\$7,900,776	
	Buildings . . . . .	18,491,903	19,201,351		OWNER EQUITY	OWNERS' EQUITY, list below:		
	Leasehold improvements . . . . .	709,447	-			Investment in Capital Assets	15,440,069	16,271,664
	Fixed equipment . . . . .	-	-			Restricted Pension	445,094	(539,970)
	Moveable equipment . . . . .	1,794,329	1,755,339			Net income (Loss)	(153,469)	2,087,191
	Transportation equipment . . . . .	13,020	-			TOTAL OWNER'S EQUITY . . . . .	\$15,731,694	\$17,818,885
	Other . . . . .	164,048	1,510,603					
	Less: accumulated depreciation . . . . .	(6,430,435)	(6,893,385)					
	TOTAL PROPERTY, PLANT, EQUIPMENT	\$15,440,068	\$16,271,664					
OTHER	Long term investments . . . . .							
	Other Assets, list below:							
	Deferred Outflow - Resource Pension	4,061,412	4,606,089					
TOTAL OTHER ASSETS . . . . .	\$4,061,412	\$4,606,089						
<b>TOTAL ASSETS . . . . .</b>	<b>\$24,316,104</b>	<b>\$26,144,394</b>		<b>TOTAL LIABILITIES AND EQUITY . . . . .</b>	<b>\$24,316,104</b>	<b>\$26,144,394</b>		

**SCHEDULE 10A: Summary of Changes to Equity**

1. Beginning Owners' Equity (from schedule 10) .....		<u>\$15,731,694</u>
2. Add		
Net income (from schedule 11, line 19)	<u>\$2,069,826</u>	
Owners' capital contribution	<u>-</u>	
County appropriation	<u>3,364,317</u>	
Net decrease in accrued vacation, holiday and sick time	<u></u>	
Other, Specify: <u>Restricted Pension Liability</u>	<u>1,307,915</u>	
Other, Specify: <u>N/A</u>	<u>-</u>	
Total additions .....		<u>6,742,058</u>
3. Deduct		
Net loss (from schedule 11, line 19)	<u>( \$- )</u>	
Dividends and withdrawals	<u>( )</u>	
Net increase in accrued vacation, holiday and sick time	<u>( )</u>	
Other, Specify: <u>Deficit Other programs</u>	<u>( 4,654,867 )</u>	
Other, Specify: <u></u>	<u>( )</u>	
Total deductions .....		<u>( 4,654,867 )</u>
 4. ENDING OWNERS' EQUITY (schedule 10) .....		 <u>\$17,818,885</u>



## SCHEDULE 11: Summary of Revenues & Expenses

All values are automatically posted from other schedules.

### SECTION A - SUMMARY OF REVENUE

1. Daily patient service revenue . . . . .	schedule 14, lines 1-4	\$ 7,892,316
2. Service fees . . . . .	schedule 15, line 14A	405,078
3. Rent from outside medical providers . . . . .	schedule 15, line 14B	-
4. Other . . . . .	schedule 15, line 14C	31,644
5. Dietary revenues . . . . .	schedule 16, line 5A	2,262
6. Miscellaneous services and materials revenue . . . . .	schedule 16, line 16	2,797
7. Rental revenues . . . . .	schedule 17, line 22	219,155
8. Revenues from other major activities . . . . .	schedule 17, line 38	4,652,502
9. Sales to related organizations . . . . .	schedule 18, line 41	-
10. Investment revenue . . . . .	schedule 18, line 42	-
11. Gains (Losses) on disposal of assets . . . . .	schedule 18, line 43	-
12. Grants for government-subsidized employees . . . . .	schedule 18, line 44	-
13. Grants, contributions, donations . . . . .	schedule 18, line 45	752,403
14. Other revenue . . . . .	schedule 18, line 50	6,334,133
15. Subtract: deductions from revenues . . . . .	schedule 14, line 5	( 3,444,007 )
16. NET REVENUES . . . . .		\$ 16,848,283

### SECTION B - SUMMARY OF NET INCOME OR LOSS

17. Subtract: total expenses . . . . .	schedule 12, line 37	\$ ( 14,778,457 )
18. Add or subtract the amount to adjust related party transactions to cost . . . . .	schedule 42, line 15	-
19. NET INCOME OR LOSS . . . . .		\$ 2,069,826

**SCHEDULE 12: Summary of Total Expenses**

All values are automatically posted from other schedules.

Cost Center	Reference	Expense	Cost Center	Reference	Expense
1. Daily patient service expense . . . . .	S20, L10	<u>\$3,440,164</u>	20. Transportation . . . . .	S25, L14f	<u>\$797</u>
2. Laboratory & Radiology . . . . .	S21, L13a	<u>-</u>	21. Administrative service expense . . . . .	S26, L12	<u>2,542,116</u>
3. Respiratory . . . . .	S21, L13b	<u>-</u>	Other cost centers, Specify:		
4. Pharmacy . . . . .	S21, L13c	<u>22,639</u>	22. Nurse Aide Training . . . . .	S27, L16a	
5. PT, OT and Speech . . . . .	S22, L13a	<u>362,036</u>	23. Beauty/Barber Shop . . . . .	S27, L16b	
6. Dental . . . . .	S22, L13b	<u>-</u>	24. Hospital . . . . .	S27, L16c	<u>2,451,267</u>
7. Physician . . . . .	S22, L13c	<u>675</u>	25. CBRF . . . . .	S27, L16d	<u>350,569</u>
8. Social Services . . . . .	S23, L13a	<u>318,011</u>	26. 0 . . . . .	S27, L16e	
9. Recreational Activities . . . . .	S23, L13b	<u>2,084</u>	UNASSIGNED EXPENSES		
10. Religious Services . . . . .	S23, L13c	<u>-</u>	27. Employee fringe benefit expense . . . . .	S28, L17	<u>2,122,689</u>
11. Volunteer Coordinator . . . . .	S24, L13a	<u>-</u>	28. Heating fuel and utility expense . . . . .	S29, L10	<u>200,576</u>
12. Ward Clerks . . . . .	S24, L13b	<u>-</u>	29. Interest on operating working capital loans . . . . .	S30, L6	<u>-</u>
13. Psychotherapy . . . . .	S24, L13c	<u>-</u>	30. Insurance expense . . . . .	S31, L9	<u>103,022</u>
14. Other . . . . .	S24, L13d	<u>-</u>	31. Amortization expense . . . . .	S32, L5	<u>-</u>
15. Dietary . . . . .	S25, L14a	<u>876,353</u>	32. Interest on plant asset loans . . . . .	S33, L15h	<u>336,536</u>
16. Plant Operations and Maintenance . . . . .	S25, L14b	<u>1,090,137</u>	33. Depreciation expense . . . . .	S34, L20c	<u>514,959</u>
17. Housekeeping . . . . .	S25, L14c	<u>-</u>	34. Expense on operating and non-cap.leases . . . . .	S35, L14	<u>-</u>
18. Laundry and Linen . . . . .	S25, L14d	<u>43,827</u>	35. Expense on capitalized leases . . . . .	S36A, L5	<u>-</u>
19. Security . . . . .	S25, L14e	<u>-</u>	36. Property tax expense . . . . .	S37, L7	<u>-</u>
			<b>37. TOTAL EXPENSES FOR REPORT PERIOD</b>		<b><u>\$14,778,457</u></b>
			(To schedule 11, line 17)		

### SCHEDULE 13: Summary of Salary & Wage Expenses

All values are automatically posted from other schedules.

Cost Center and Schedule	Total Salary and Wage Expense	Cost Center and Schedule	Total Salary and Wage Expense
Daily patient service . . . . . S20, L1d	\$2,979,902	Dietary . . . . . S25, L1a	506,450
Laboratory & Radiology . . . . . S21, L1a	-	Plant operation / maintenance. . . . . S25, L1b	-
Respiratory . . . . . S21, L1b & 3b	-	Housekeeping . . . . . S25, L1c	-
Pharmacy . . . . . S21, L1c & 3c	-	Laundry and Linen . . . . . S25, L1d	-
PT, OT and Speech . . . . . S22, L1a & 3a	145,577	Security . . . . . S25, L1e	-
Dental . . . . . S22, L1b & 3b	-	Transportation . . . . . S25, L1f	-
Physician . . . . . S22, L1c & 3c	-	Administrative service . . . . . S26, L5	1,008,592
Social Services . . . . . S23, L3a	318,011	Nurse aide training . . . . . S27, L1a	-
Recreational Activities . . . . . S23, L3b	-	Beauty and barber . . . . . S27, L1b	-
Religious Services . . . . . S23, L3c	-	Other, Specify: <u>Hospital</u> . . . . . S27, L1c	2,208,993
Volunteer Coordinator . . . . . S24, L3a	-	<u>CBRF</u> . . . . . S27, L1d	331,331
Ward Clerks . . . . . S24, L3b	-	<u>0</u> . . . . . S27, L1e	-
Psychotherapy . . . . . S24, L1c & 3c	-	<b>TOTAL SALARY AND WAGE EXPENSE. . . . .</b>	<b>\$7,498,856</b>
Other . . . . . S24, L1d & 3d	-		

**SCHEDULE 14: Daily Patient Service Revenues**

**SECTION A - DAILY RATE CHARGES**

	Revenue
1. Medicare Daily Rate	<u>\$90,376</u>
2. Medicaid Daily Rate (including bed hold)	<u>7,189,919</u>
3. Private Pay	<u>612,021</u>
4. Medical Supplies, Other	<u>-</u>

**SECTION B - Deductions From Revenue**

5. TOTAL DEDUCTIONS FROM REVENUE ( 3,444,007 )

**SECTION C - TOTAL**

6. TOTAL DAILY PATIENT SERVICE REVENUE \$4,448,309

Do Medicaid revenues on Line 2 include retroactive Medicaid rate adjustments? (check one)

- Yes, all significant retroactive Medicaid rate adjustments are included.
- No, substantial retroactive Medicaid rate adjustments are NOT included.
- Estimate, an estimate of retroactive Medicaid rate adjustments IS included
- Other, Specify \_\_\_\_\_

**Average Daily Private Pay Rate**

7. Average Daily \$422.00  
 8. Facility Comment (Optional)

**SCHEDULE 15: Special Services Revenue**

SECTION A - SERVICE REVENUES	A. Service Fee Charges	B. Rent from Outside Medical Providers	C. From Other Sources	Describe Other
1. Laboratory .....				
2. Radiology .....				
3. Pharmacy .....				
4. Physical therapy .....	102,650			
5. Speech/hearing therapy .....	54,096			
6. Occupational therapy .....	133,421			
7. Physician care .....	114,911			
8. Psychotherapy .....				
9. Respiratory therapy				
10. Social services .....				
11. Recreational activities .....				
12. Special duty nursing .....				
13. Other, Specify: <u>Active Treatment</u>			31,644	State Funding
14. TOTAL SPECIAL SERVICE REVENUE ..	<u>\$405,078</u>	<u>\$-</u>	<u>\$31,644</u>	

**SECTION B - THERAPY REVENUES**

15. Are physical, occupational, or speech therapy services provided by staff, assistants, contractors, or consultants IN SPACE AT YOUR FACILITY?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
16. Total gross billings for physical, occupational, and speech therapy services provided at your facility during the cost report period Provide the total regardless of who provides the services, who bills for the services, or who receives the services (residents vs. non-residents).			<u>\$290,167</u>
17. From section A, total the amounts in columns A, B and C on lines 4, 5 and 6 (sum 4A, 4B, 4C, 5A, 5B, 5C, 6A, 6B, 6C)			<u>\$290,167</u>
18. If there is any variance between the totals reported on lines 16 and 17, explain.	<hr/>		
19. Are therapy services provided to individuals in addition to your nursing home residents?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, amount of revenue
20. Does your facility or related organization bill Medicare Part B for therapy services at your facility?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, amount of revenue
21. Did you charge rent to a rehabilitation agency or independent contractor?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, amount of revenue

**SCHEDULE 16: Other Revenues**

**SECTION A - CAFETERIA AND DIETARY REVENUE**

1. Donated and surplus food commodities .....	_____	Included in food supply expense for donated/surplus .....	_____
2. Dietary supplies sold .....	_____	Cost of dietary supplies sold (if known) .....	_____
3. Meals sold to employees (transfer to sched. 25A, line 10) .....	<u>2,199</u>		
4. Meals On Wheels .....	_____		
5. Other Meals Sold .....	<u>63</u>		
<b>5a. TOTAL DIETARY REVENUE .....</b>	<b><u>\$2,262</u></b>		

**SECTION B - MISCELLANEOUS SERVICES AND MATERIALS**

	Revenue	<u>Expenses Directly Ascribable To Or Identifiable With Revenue</u>			
		A. Related Direct Expense (if known)	B. Cost Center where expense included	C. Schedule Number	D. Line Number
6. Laundry .....	_____	_____	_____	_____	_____
7. Sale of personal hygiene items .....	_____	_____	_____	_____	_____
8. Transportation .....	_____	_____	_____	_____	_____
9. Beauty and barber shops .....	_____	_____	_____	_____	_____
10. Gift Shop .....	_____	_____	_____	_____	_____
11. Canteen and snack counter .....	<u>2,780</u>	_____	_____	_____	_____
12. Vending machines .....	<u>17</u>	_____	_____	_____	_____
13. Sale of clothing .....	_____	_____	_____	_____	_____
14. Television and cable service .....	_____	_____	_____	_____	_____
15. Telephone and Internet .....	_____	_____	_____	_____	_____
<b>16. TOTAL MISCELLANEOUS SERVICES AND MATERIALS</b>	<b><u>\$2,797</u></b>				

**SCHEDULE 17: Other Revenues**

<b>SECTION A - RENTAL REVENUE</b>	<b>Revenue</b>	<b>Property Rented</b>	<b>Square Feet Rented</b>	<b>Services Provided</b>
18. Equipment rental . . . . .				
19. Rental of nursing home space . . . . .				
20. Rental of non-nursing home space . . . . .	219,155	Building Space		
21. Parking . . . . .				
<b>22. TOTAL RENTAL REVENUES . . . . .</b>	<b>\$219,155</b>			

<b>SECTION B - REVENUE FROM MAJOR ACTIVITIES</b>	<b>Revenue</b>	<b>Total Billable Patient Days if revenue generated from activities</b>
23. Another Medicaid nursing home provider . . . . .	\$4,073,267	
24. Hospital . . . . .		
25. Non-Medicaid Nursing Home . . . . .		
26. Non-Medicaid CBRF . . . . .		
27. Apartment Units . . . . .		
28. Room and Board - Other . . . . .		
29. Adult Day Care . . . . .		
30. Home Health . . . . .		
31. Child Care . . . . .		
32. Clinic . . . . .		
33. _____		
34. Outpatient Lab	8,156	
35. CBRF	571,079	
36. N/A	-	
37. _____		
<b>38. TOTAL REVENUE FROM OTHER MAJOR ACTIVITIES . . . . .</b>	<b>\$4,652,502</b>	

**SCHEDULE 18: Other Revenues**

		<u>Revenue</u>
	SALES TO RELATED ORGANIZATIONS	
38.	_____	_____
39.	_____	_____
40.	_____	_____
41.	TOTAL SALES TO RELATED ORGANIZATIONS	\$-
42.	TOTAL INVESTMENT REVENUE .....	_____
43.	TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS .....	_____
44.	TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES .....	_____
45.	TOTAL GRANTS, CONTRIBUTIONS, DONATIONS .....	\$752,403
	OTHER REVENUES	
46.	NH State Supplemental	\$1,224,693
47.	Misc	4,004
48.	Intracounty transfers	428,484
49.	Capital contribution intra county and county levy	4,676,952
50.	TOTAL OTHER REVENUES .....	<u>\$6,334,133</u>



**SCHEDULE 20: Daily Patient Service Expense**

<u>Salaries, Wages &amp; Purchased Serv.</u>	<u>A. Registered Nurses</u>	<u>B. Licensed Practical Nurses</u>	<u>C. Nurse Aides and Assistants</u>	<u>D. Total Expense or Hours</u>
1. TOTAL SALARY AND WAGE EXPENSE	\$679,935	\$288,342	\$2,011,625	\$2,979,902
2. TOTAL SALARY AND WAGE HOURS	22,660 hrs.	13,017 hrs.	114,116 hrs.	\$149,793
3. EXPENSE FOR PURCHASED SERVICES	\$22,715	\$26,698	\$170,735	\$220,148
AVERAGE WAGE PER HOUR	\$30.01	\$22.15	\$17.63	\$19.89
<b>NURSING AND INCONTINENCY SUPPLIES</b>				
4. Catheters, Incontinency Supplies (including purchased laundry service)				\$38,891
<b>OXYGEN</b>				
5. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental				-
<b>OTHER</b>				
6. Other medical supplies, personal comfort supplies and minor medical equipment				184,566
7. Nonbillable over the counter (OTC) drugs for all residents (include billable OTC drugs on Schedule 21, Line 9c)				
8. <u>Equipment rental</u>				13,305
9. <u>Medical Services</u>				3,352
10. <b>TOTAL DAILY PATIENT SERVICE EXPENSE</b>				<b><u>\$3,440,164</u></b>

### SCHEDULE 21: Special Service Expenses

SECTION A - SALARY AND WAGES	TYPE OF SERVICE		
	<u>A. Laboratory &amp; Radiology</u>	<u>B. Respiratory</u>	<u>C. Pharmacy</u>
1. Expense for hours worked - Billable	_____	_____	_____
2. Number of hours worked - Billable	_____	_____	_____
3. Expense for hours worked - Non-billable	_____ \$-	_____	_____
4. Number of hours worked - Non-billable	_____ hrs.	_____	_____
5. TOTAL SALARY AND WAGE EXPENSE	_____ \$-	_____ \$-	_____ \$-
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable	_____	_____	_____
7. Expense for purchased service - Non billable	_____ \$-	_____	_____
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
8. Pharmacy - legend drugs Billable	_____ \$-	_____ \$-	_____
9. Pharmacy - over the counter drugs Billable	_____ \$-	_____ \$-	_____
10. Supply and Other	_____	_____	_____
11. Medications	_____	_____	_____ 22,639
12. _____	_____	_____	_____
<b>SECTION D - TOTAL</b>			
13. TOTAL EXPENSES	_____ \$-	_____ \$-	_____ \$22,639
14. TOTAL HOURS	_____ hrs.	_____ hrs.	_____ hrs.

**SCHEDULE 22: Special Service Expenses**

	TYPE OF SERVICE		
	A. Physical, Occupational And Speech Therapy	B. Dental	C. Physician
<b>SECTION A - SALARY AND WAGES</b>			
1. Expense for hours worked - Billable.....			
2. Number of hours worked - Billable.....			
3. Expense for hours worked - Non-billable.....	\$145,577		
4. Number of hours worked - Non-billable.....	5,161 hrs.		
5. TOTAL SALARY AND WAGE EXPENSE	\$145,577	\$-	\$-
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable.....	\$111,893		\$675
7. Expense for purchased service - Non billable.....	\$31,213		
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
8. Resident Entertainment	303		
9. Supplies	68,422		
10. Travel and Training	467		
11. Book, Dues	4,161		
12. _____			
<b>SECTION D - TOTAL</b>			
13. TOTAL EXPENSES.....	\$362,036	\$-	\$675
14. TOTAL HOURS.....	5,161 hrs.	hrs.	hrs.

### SCHEDULE 23: Special Service Expenses

	TYPE OF SERVICE		
	A. Social Services	B. Recreational Activities	C. Religious Services
<b>SECTION A - SALARY AND WAGES</b>			
1. Expense for hours worked - Billable	\$-	\$-	\$-
2. Number of hours worked - Billable	hrs.	hrs.	hrs.
3. Expense for hours worked - Non-billable	\$318,011	\$-	
4. Number of hours worked - Non-billable	7,262 hrs.	hrs.	
5. TOTAL SALARY AND WAGE EXPENSE	\$318,011	\$-	\$-
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable	\$-	\$-	\$-
7. Expense for purchased service - Non billable			
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
8. <u>Aviary Maint</u>		\$450	
9. _____			
10. _____			
11. <u>Resident Store</u>		1,634	
12. _____			
<b>SECTION D - TOTAL</b>			
13. TOTAL EXPENSES	\$318,011	\$2,084	\$-
14. TOTAL HOURS	7,262 hrs.	hrs.	hrs.

**SCHEDULE 24: Special Service Expenses**

	TYPE OF SERVICE			
	A. Volunteer Coord.	B. Ward Clerks	C. Psychotherapy	
<b>SECTION A - SALARY AND WAGES</b>				
1. Expense for hours worked - Billable	\$-	\$-		
2. Number of hours worked - Billable	hrs.	hrs.		
3. Expense for hours worked - Non-billable				
4. Number of hours worked - Non-billable				
5. TOTAL SALARY AND WAGE EXPENSE	\$-	\$-	\$-	\$-
<b>SECTION B - PURCHASED SERVICES</b>				
6. Expense for purchased service - Billable				
7. Expense for purchased service - Non billable				
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>				
8.				
9.				
10.				
11.				
12.				
<b>SECTION D - TOTAL</b>				
13. TOTAL EXPENSES	\$-	\$-	\$-	
14. TOTAL HOURS	hrs.	hrs.	hrs.	hrs.

### SCHEDULE 25: General Service Expenses

SECTION A - SALARIES AND WAGES	A. Dietary	B. Plant Op./Maint.	C. Housekeeping	D. Laundry / Linen	E. Security	F. Transportation
1. TOTAL SALARY AND WAGE EXPENSE	\$506,450					
2. NUMBER OF HOURS WORKED	29,071 hrs.					
<b>SECTION B - DIETICIAN CONSULTANT</b>						
3. Dietician consultant expense		\$-	\$-	\$-	\$-	\$-
<b>SECTION C - OUTSIDE SERVICE</b>						
4. Contract laundry				\$34,455		
5. Contract dietary	50,019					
6.						
7.						
8. TOTAL OUTSIDE SERVICE EXPENSES	\$50,019	\$-	\$-	\$34,455	\$-	\$-
<b>SECTION D - SUPPLY AND OTHER EXPENSE</b>						
9. Food and Supplements	\$271,501					
10. Supplies	39,567	12,015				
11. Repairs & maintenance	8,816	44,282				797
12. Inter dept Service		1,033,840		9,372		
13.						
<b>SECTION E - TOTAL</b>						
14. TOTAL EXPENSES .....	<b>\$876,353</b>	<b>\$1,090,137</b>	<b>\$-</b>	<b>\$43,827</b>	<b>\$-</b>	<b>\$797</b>

**SCHEDULE 25A: Support Services Expense Allocations**

**SECTION A - ALLOCATION OF DIETARY EXPENSES**

1. Total dietary expenses (from Schedule 25, Line 14a)	<u>\$876,353</u>
2. Deduct expense for food products provided to employees without charge (to line 9 below)	
3. Deduct amount for donated and surplus food commodities included in dietary expense (from schedule 16, line 1) . . . . .	<u>\$-</u>
4. Deduct revenue (related expense) for food products sold (from schedule 16, line 2)	<u>\$-</u>
5. NET DIETARY EXPENSES TO ALLOCATE (to line 8 A below)	<u>\$876,353</u>

	A. Total	B. Residents'	C. Employees'	D. Meals on	E. Other	F. Other
		Meals	Meals	Wheels	Hospital	CBRF
6. Meals served	<u>108,786</u>	<u>86,424</u>	<u>505</u>		<u>14,075</u>	<u>7,782</u>
7. Ratio to total meals served to 4 decimals	<u>1.0000</u>	<u>0.7944</u>	<u>0.0046</u>		<u>0.1294</u>	<u>0.0715</u>
8. DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	<u>\$876,353</u> <small>From line 5</small>	<u>\$696,175</u> <small>8A x 7B</small>	<u>\$4,031</u> <small>8A x 7C</small>	<u>\$-</u> <small>8A x 7D</small>	<u>\$113,400</u> <small>8A x 7E</small>	<u>\$62,659</u> <small>8A x 7F</small>
9. Food products provided to employees without charge (from line 2)			<u>\$-</u>			
10. Deduct revenue from meals sold to employees (from schedule 16, line 3)			<u>2,199</u>			
11. NET EXPENSE (PROFIT) FOR MEALS AND FOOD PROVIDED TO EMPLOYEES (line 8C + line 9C - line 10C)			<u>\$1,832</u>			

**SECTION B - ALLOCATION OF PLANT OPERATION AND MAINTENANCE EXPENSES**

	A. Total	B. Nursing Home	C. Emp. Unique	Non-Nursing Home Areas w/ Plant Operation and Maint.		
	Area	Area	Fringe Benefit Area	D. Rented Clinic space	E. Hospital/CBRF	F. Therapy
12. Total square feet for areas	<u>102,154</u>	<u>70,817</u>		<u>9,519</u>	<u>19,379</u>	<u>2,439</u>
13. Ratio to total square feet to 4 decimals . .	<u>1.0000</u>	<u>0.6932</u>		<u>0.0932</u>	<u>0.1897</u>	<u>0.0239</u>
14. TOTAL PATIENT OP/MAINT EXP. ALLOC. <small>From S25, L18</small>	<u>\$1,090,137</u> <small>From S25, L18</small>	<u>\$755,683</u> <small>14A x 13B</small>	<u>\$-</u> <small>14A x 13C</small>	<u>\$101,601</u> <small>14A x 13D</small>	<u>\$206,799</u> <small>14A x 13E</small>	<u>\$26,054</u> <small>14A x 13F</small>

**SCHEDULE 25B: Support Services Expense Allocations**

**SECTION A - ALLOCATION OF HOUSEKEEPING EXPENSES**

**Non-Nursing Home Areas Receiving Housekeeping Services**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>Hospital</u>	<u>CBRF</u>	<u>Other</u>
15. Square feet or hours of service provided	102,153	70,817	12,419	6,960	11,957
16. Ratio to total sq. ft./hours to 4 decimals	1.0000	0.6932	0.1216	0.0681	0.1170
17. TOTAL HOUSEKEEPING EXP. ALLOC.	\$-	\$-	\$-	\$-	\$-
	From S25, L18	17A x 16B	17A x 16C	17A x 16D	17A x 16E

**SECTION B - ALLOCATION OF LAUNDRY AND LINEN EXPENSES**

**Non-Nursing Home Areas Receiving Laundry/Linen Services**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>Hospital</u>		
18. Pounds of laundry processed	133,629	113,191	20,438		
19. Ratio to total pounds to 4 decimals . . . . .	1.0000	0.8471	0.1529		
20. TOTAL LAUNDRY/LINEN EXP. ALLOC.	\$43,827	\$37,126	\$6,701	\$-	\$-
	From S25, L18	20A x 19B	20A x 19C	20A x 19D	20A x 19E

**SECTION C - ALLOCATION OF SECURITY EXPENSES**

**Non-Nursing Home Areas Receiving Security Services**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			
21. Total square feet of area	-				
22. Ratio to total square feet to 4 decimals . .	1.0000				
23. TOTAL SECURITY EXPENSE ALLOC.	\$-	\$-	\$-	\$-	\$-
	From S25, L18	23A x 22B	23A x 22C	23A x 22D	23A x 22E

**SECTION D - ALLOCATION OF TRANSPORTATION EXPENSES**

**Non-Nursing Home Areas Receiving Transportation Services**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			<u>Other</u>
24. Alloc. Basis, Specify: <u>Miles</u>	28,229	1,890			26,339
25. Ratio to total alloc. basis to 4 decimals	1.0000	0.0670			0.9330
26. TOTAL TRANS. EXPENSE ALLOC.	\$797	\$53	\$-	\$-	\$744
	From S25, L18	26A x 25B	26A x 25C	26A x 25D	26A x 25E



**SCHEDULE 26: Administrative Service Expenses**

		<b>Expenses</b>
<b>SECTION A - SALARY AND WAGES</b>		
1.	General Admin & Accounting	\$779,982
2.	Medical Records	174,407
3.	Central Supply	
4.	Scheduling	54,203
5.	Total Salary and Wage Expense	\$1,008,592
<b>SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS</b>		
6.	Home office costs allocated to facility	
	Name of home office _____	
	From (date) _____	
	Through (date) _____	
7.	County costs allocated to facility	500,554
<b>SECTION C - NON-SALARY EXPENSES</b>		
8.	Purchased services - legal	
9.	Licensed bed assessment	128,520
10.	Contractual management fees	
11.	Total other non-salary (from schedule 26 attachment)	904,450
<b>SECTION D - TOTAL</b>		
12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES	<b>\$2,542,116</b>

**SCHEDULE 26ATT: Administrative Service Expenses - Other Non-Salary**

<b>Description of Other Non-Salary Administrative Service Expenses</b>	<b>Expense Amount</b>
1. <u>Supplies</u>	<u>\$29,602</u>
2. <u>Dues/Memberships</u>	<u>314</u>
3. <u>Printing Expense</u>	<u>29,367</u>
4. <u>Travel &amp; Education</u>	<u>4,362</u>
5. <u>Books &amp; Periodicals</u>	<u>5,284</u>
6. <u>Repairs</u>	<u>3,167</u>
7. <u>Permits</u>	<u>666</u>
8. <u>Service Fees</u>	<u>5,848</u>
9. <u>Telephone</u>	<u>13,092</u>
10. <u>Equipment Non-Outlay</u>	<u>65,085</u>
11. <u>Software Support</u>	<u>221,657</u>
12. <u>Information Services</u>	<u>392,696</u>
13. <u>Special Assessments</u>	<u>1,610</u>
14. <u>Intra dept staff allocation</u>	<u>116,328</u>
15. <u>Contracted Services</u>	<u>15,372</u>
16. <b>TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11) .....</b>	<b><u>\$904,450</u></b>

**SCHEDULE 26: Related Party Administrative Service Expenses**

		Expenses
<b>SECTION A - SALARY AND WAGES</b>		
1.	General Admin & Accounting	_____
2.	Medical Records	_____
3.	Central Supply	_____
4.	Scheduling	_____
5.	Total Salary and Wage Expense	\$-
<b>SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS</b>		
6.	Home office costs allocated to facility	_____
	Name of home office	_____
	From (date)	_____
	Through (date)	_____
7.	County costs allocated to facility	_____
<b>SECTION C - NON-SALARY EXPENSES</b>		
8.	Purchased services - legal	_____
9.	Licensed bed assessment	_____
10.	Contractual management fees	_____
11.	Total other non-salary (from schedule 26 attachment)	-
<b>SECTION D - TOTAL</b>		
12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES	\$-

### SCHEDULE 26ATTRP: Related Party Administrative Service Expenses - Other Non-Salary

Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____
16. <b>TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11)</b> . . . . .	<b>\$-</b>

**SCHEDULE 26B: Allocation of Administrative Expenses**

1. Total Admin. Service Expense (S26, 12) \$2,542,116

**SECTION A - DIRECT EXPENSES**

**Non-Nursing Home Areas Receiving Administrative Services**

Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider	0	0	0
2. 0	\$-	\$-			
3.	-				
4.	-				
5.	-				
6.	-				
7.	-				
8.	-				
9.	-				
10.	-				
11.	-				
12.	-				
13.	-				
14.	-				
15. TOTAL DIRECT EXPENSE.....	\$-	\$-			
16. NET UNASSIGNED EXPENSE	<u>\$2,542,116</u>				

**SECTION B - ALLOC. OF INDIRECT EXP.**

	A. Total	B. NH Provider	-	-	-
17. Allocation basis amounts .....	92	57	30	5	-
18. Ratio to total basis to 4 decimals .....	1.0000	0.6196	0.3261	0.0543	0.0000
19. UNASSIGNED ADMIN. EXP. ALLOC .....	\$2,542,116	1,575,095	828,984	138,037	-
	net from line 16	19A x 18B	19A x 18C	19A x 18D	19A x 18E
20. TOTAL ADMINISTRATIVE EXPENSE .....	\$2,542,116	\$1,575,095	\$828,984	\$138,037	\$-
	(line 15A + 19A)	B15 + B19	C15 + C19	D15 + D19	E15 + E19

**SCHEDULE 27: Other Cost Centers**

<b>SECTION A - SALARY AND WAGES</b>		<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>	<u>Hospital</u>	<u>CBRF</u>	
1.	TOTAL SALARY AND WAGE EXPENSE			\$2,208,993	\$331,331	
2.	NUMBER OF HOURS WORKED			89,823 hrs.	18,494 hrs.	
<hr/>						
<b>SECTION B - NON-SALARY EXPENSES</b>		<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>	<u>Hospital</u>	<u>CBRF</u>	
3.	Hospital Other			\$242,274		
4.	CBRF Other				19,238	
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.	<b>TOTAL NON-SALARY EXPENSES</b>	\$-	\$-	\$242,274	\$19,238	\$-
<hr/>						
<b>SECTION C - TOTAL</b>		<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>	<u>Hospital</u>	<u>CBRF</u>	
16.	<b>TOTAL EXPENSES</b> .....			\$2,451,267	\$350,569	-

**SCHEDULE 28: Fringe Benefits**

Fringe Benefits Paid on Behalf of Employees	Self-Funded?	Expense
1. Employer's share of F.I.C.A.		\$530,517
2. State unemployment compensation		7,585
3. Federal unemployemnt compensation		
4. Worker's compensation insurance	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	153,130
5. Health, Dental & Vision Insurance	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	816,178
6. Life and disability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	57,213
7. Wage continuation insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Pension and deferred comp. plans (section C)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	558,066
9. Post-Employment Physicals and Vaccines		
10. Uniforms		
11. _____		
12. _____		
13. _____		
14. _____		
15. TOTAL PAID ON BEHALF OF EMPLOYEEES		<b>\$2,122,689</b>
16. Expense for special salary or wage payments to employees not included elsewhere		
<input type="checkbox"/> Christmas bonus <input type="checkbox"/> Longevity bonus <input type="checkbox"/> Productivity bonus <input type="checkbox"/> Bonuses to owners and immediate family relations, Specify:		
<input type="checkbox"/> Other, Specify: _____ _____		
17. TOTAL FRINGE BENEFIT EXPENSE		<b>\$2,122,689</b>

**SCHEDULE 28B: Fringe Benefits - Self-Funded**

<b>Type of Self-Funded Expenses</b>	<b>Worker's Compensation Insurance</b>	<b>Health, Dental and Vision Insurance</b>	<b>Life and Disability Insurance</b>	<b>Wage Continuation Insurance</b>	<b>Pension and Deferred Compensation Plans</b>
Checked as self-funded on Sch 28?	<b>x</b>	<b>x</b>			
1 Actual Claims Paid	\$93,890	\$875,610			
2 Premium costs for re-insurance (stop loss) policies purchased from an unrelated party	23,241	49,676			
3 Costs paid to administer the self insurance plan not reported elsewhere in the cost report	38,094	46,442			
4 Costs paid to an independent unrelated trustee to manage the self-insurance plan	-	-			
5 Costs paid to an unrelated actuary to perform actuarial determinations	-	4,035			
6 Employee Contributions	-	157,786			
7 Proceeds from re-insurance (stop loss) policies, dividend proceeds, and audit adjustment cost decreases or (increases)	-	-			
8 Investment income earned by the self insurance fund	2,095	1,799			
9 Gain on the sale of self insurance fund securities	-	-			
10 Total allowable self-funded fringe benefit expenses (add lines 1 thru 5 and subtract lines 6 thru 9)	\$153,130	\$816,178	\$-	\$-	\$-



**SCHEDULE 29: Heating and Utility Service Expenses**

**SECTION A - ACCRUED EXPENSE BY TYPE**

	<u>Accrued Expense</u>	<u>Expense by Type</u>	<u>Accrued Expense</u>
1. Fuel oil	57,652	6. Water and sewer utility charges	27,778
2. Natural gas		7. Purchased steam	
3. L.P. gas		8. _____	
4. Coal		9. _____	
5. Electricity	115,146	<b>10. TOTAL FUEL AND UTILITY EXPENSE . . .</b>	<b>200,576</b>

**SECTION B - ALLOCATION OF FUEL AND UTILITY EXPENSE**

	<u>A. Total</u>	<u>B. NH Area</u>	<u>C. Emp. Unique Fringe Ben. Area</u>	<u>Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv.</u>		
				<u>Hospital</u>	<u>CBRF</u>	<u>Other</u>
11. Total square feet for areas	102,153	70,817		12,419	6,960	11,957
12. Ratio to total square feet to 4 decimals	1.0000	0.6932		0.1216	0.0681	0.1170
<b>13. TOTAL ALLOC. FUEL/UTIL. EXPENSE</b>	<b>200,576</b>	<b>\$139,039</b>	<b>\$-</b>	<b>\$24,390</b>	<b>\$13,659</b>	<b>\$23,467</b>
	From line 10	13A x 12B	13A x 12C	13A x 12D	13A x 12E	13A x 12F

### SCHEDULE 30: Working Capital Loans

A. Name of Lender	B. Is Lender a Related Party?	C. Interest Expense
1. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. <b>TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS</b> .....		<b>\$-</b>

### SCHEDULE 31: Accrued Insurance Expenses

A. Type of Insurance Coverage	B. Self-Funded?	C. Insurance Expense
1. Property insurance on building and contents	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$18,099
2. Automobile insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1,539
3. Liability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	56,430
4. Business interruption insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. Life insurance on owners and employes with facility as the beneficiary .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Mortgage insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7. Other Property _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8. Other General <u>Professional Liability and Casualty</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26,954
9. <b>TOTAL INSURANCE EXPENSE</b> .....		<b>\$103,022</b>

### SCHEDULE 32: Amortized Expenses

A. Bond Issue	B. Sch. 33 Line Number	C. Original Amount	D. Number of Years Amortized	E. Unamortized Begin. Balance	F. Unamortized End. Balance	G. Amortization Expense
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. <b>TOTAL AMORTIZATION EXPENSE</b> .....						<b>\$-</b>

### SCHEDULE 30RP: Related Party Working Capital Loans

A. Name of Lender	B. Is Lender a Related Party?	C. Interest Expense
1. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. <b>TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS</b> .....		<b>\$-</b>

### SCHEDULE 31RP: Related Party Accrued Insurance Expenses

A. Type of Insurance Coverage	B. Self-Funded?	C. Insurance Expense
1. Property insurance on building and contents	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. Automobile insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Liability insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. Business interruption insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. Life insurance on owners and employes with facility as the beneficiary .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Mortgage insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9. <b>TOTAL INSURANCE EXPENSE</b> .....		<b>\$-</b>

### SCHEDULE 32RP: Related Party Amortized Expenses

A. Bond Issue	B. Sch 33RP Line Number	C. Original Amount	D. Number of Years Amortized	E. Unamortized Begin. Balance	F. Unamortized End. Balance	G. Amortization Expense
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. <b>TOTAL AMORTIZATION EXPENSE</b> .....						<b>\$-</b>

**SCHEDULE 33: Plant Asset Loans**

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month, Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal			G. Interest Rate	H. Interest Expense
				D. Begin date 1/1/2020	E. 6Mo. date 6/30/2020	F. End date 12/31/2020		
				Begin Bal.	6 Mo. Bal.	End Bal.		
1. Name <u>2016C GO Bonds</u> Related party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Purpose <u>Replacement bond funding for CTC facility</u>	<u>Nov-16</u>	<u>Nov-36</u>	<u>\$1,265,000</u>	<u>\$431,200</u>	<u>\$431,200</u>	<u>\$291,500</u>	<u>3.00%</u>	<u>\$12,936</u>
2. Name <u>2017B GO Bonds</u> Related party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Purpose <u>Replacement bond funding for CTC facility</u>	<u>Nov-17</u>	<u>Nov-36</u>	<u>\$1,932,000</u>	<u>\$14,785,000</u>	<u>\$14,785</u>	<u>\$12,977,000</u>	<u>2.00%</u>	<u>\$323,600</u>
3. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
4. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
5. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
6. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
7. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
<b>15 TOTAL LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2).....</b>				<b><u>\$15,216,200</u></b>	<b><u>\$445,985</u></b>	<b><u>\$13,268,500</u></b>		<b><u>\$336,536</u></b>

**SCHEDULE 33P2: Plant Asset Loans- Page 2**

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month, Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal			G. Interest Rate	H. Interest Expense
				D. Begin date	E. 6Mo.date	F. End date		
				1/1/2020	6/30/2020	12/31/2020		
				Begin Bal.	6 Mo. Bal.	End Bal.		
8. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
9. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
10. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
11. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
12. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
13. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
14. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____

SEE SCHEDULE 33 FOR TOTAL LOAN PRINCIPAL AND INTEREST EXPENSE OF SCHEDULE 33, INCLUDING PAGE 2

**SCHEDULE 33RP: Related Party Plant Asset Loans**

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month, Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal			G. Interest Rate	H. Interest Expense
				D. Begin date 1/1/2020	E. 6Mo.date 6/30/2020	F. End date 12/31/2020		
				Begin Bal.	6 Mo. Bal.	End Bal.		
1. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
2. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
3. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
4. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
5. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
6. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
7. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
<b>15 TOTAL RELATED PARTY LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2).....</b>				<b>_____ \$-</b>	<b>_____ \$-</b>	<b>_____ \$-</b>		<b>_____ \$-</b>

**SCHEDULE 33P2RP: Related Party Plant Asset Loans - Page 2**

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month, Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal			G. Interest Rate	H. Interest Expense
				D. Begin date	E. 6Mo.date	F. End date		
				1/1/2020	6/30/2020	12/31/2020		
				Begin Bal.	6 Mo. Bal.	End Bal.		
8. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
9. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
10. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
11. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
12. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
13. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
14. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____

SEE SCHEDULE 33- RELATED PARTY FOR TOTAL LOAN PRINCIPAL AND INTEREST EXPENSE OF SCHEDULE 33, INCLUDING PAGE 2

**SCHEDULE 34: Depreciation Expenses**

**SECTION A - CAPITALIZED HISTORICAL COST**

	Begin Date <u>1/1/2020</u>	C. Additions During Report	D. Disposals During Report	End Date <u>12/31/2020</u>
	B. Beginning Balance	Period	Period	E. Ending Balance
1. Land	8,509		( )	\$8,509
2. Land Improvements	689,247		( )	689,247
3. Buildings	18,883,093		( )	18,883,093
4. Leasehold Improvements	-		( )	-
5. Fixed equipment	-		( )	-
6. Moveable equipment	1,794,329		( 38,990 )	1,755,339
7. Transportation vehicles	13,020		( 13,020 )	-
8. Infrastructure	318,258		( )	318,258
9. Construction Work in Progress	164,048	1,346,556	( )	1,510,604
10. TOTAL CAPITALIZED COST . .	<b>\$21,870,504</b>	<b>\$1,346,556</b>	<b>( \$52,010 )</b>	<b>\$23,165,050</b>

**SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION**

	A. Depreciation	Begin Date <u>1/1/2020</u>	C. Depreciation Exp.	D. Removal of Accum.	End Date <u>12/31/2020</u>
	Method, Lives Used	B. Beginning Balance	During Report Period	Deprec. On Disposals.	E. Ending Balance
11. Land Improvements	SL, Various	\$305,989	\$31,622	( )	\$337,611
12. Buildings	SL, Various	4,310,261	461,319	( )	4,771,580
13. Leasehold Improvements		-	-	( )	-
14. Fixed equipment		-		( )	-
15. Moveable equipment	SL, Various	1,732,865	13,773	( 52,010 )	1,694,628
16. Transportation vehicles		-		( )	-
17. Infrastructure	SL, Various	81,321	8,245	( )	89,566
18. N/A		-		( )	-
19. TOTAL ACCUMULATED DEPRECIATION		<b>\$6,430,436</b>		<b>( \$52,010 )</b>	<b>\$6,893,385</b>
20. TOTAL DEPRECIATION EXPENSE			<b>\$514,959</b>		
21. Cost of Bariatric Equipment included with Additions reported above purchased during this cost report period				\$-	



**SCHEDULE 34RP: Related Party Depreciation Expenses**

**SECTION A - CAPITALIZED HISTORICAL COST**

	Begin Date <u>1/1/2020</u>	C. Additions During Report	D. Disposals During Report	End Date <u>12/31/2020</u>
	B. Beginning Balance	Period	Period	E. Ending Balance
1. Land	\$-		( )	\$-
2. Land Improvements	-		( )	-
3. Buildings	-		( )	-
4. Leasehold Improvements	-		( )	-
5. Fixed equipment	-		( )	-
6. Moveable equipment	-		( )	-
7. Transportation vehicles	-		( )	-
8. <u>N/A</u>	-		( )	-
9. <u>N/A</u>	-		( )	-
10. TOTAL CAPITALIZED COST . .	<u>\$-</u>	<u>\$-</u>	<u>( \$- )</u>	<u>\$-</u>

**SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION**

	A. Depreciation	Begin Date <u>1/1/2020</u>	C. Depreciation Exp.	D. Removal of Accum.	End Date <u>12/31/2020</u>
	Method, Lives Used	B. Beginning Balance	During Report Period	Deprec. On Disposals.	E. Ending Balance
11. Land Improvements		\$-		( )	\$-
12. Buildings		-		( )	-
13. Leasehold Improvements		-		( )	-
14. Fixed equipment		-		( )	-
15. Moveable equipment		-		( )	-
16. Transportation vehicles		-		( )	-
17. <u>N/A</u>		-		( )	-
18. <u>N/A</u>		-		( )	-
19. TOTAL ACCUMULATED DEPRECIATION		<u>\$-</u>		<u>( \$- )</u>	<u>\$-</u>
20. TOTAL DEPRECIATION EXPENSE			<u>\$-</u>		

21. Cost of Bariatric Equipment included with Additions reported above purchased during this cost report period

### SCHEDULE 35: Lease Expenses

**SECTION A - LEASE EXPENSE FOR LAND, BUILDING AND FIXED EQUIPMENT**

A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (If known)	E. Lease Inception Date (MM/YY)	F. Describe Property	G. Lease Exp.
1. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____

**SECTION B - LEASE EXPENSE FOR MOVEABLE EQUIPMENT AND OTHER LEASES**

A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (If known)	E. Lease Inception Date (MM/YY)	F. Describe Property	G. Lease Exp.
4. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
5. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
6. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
7. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
8. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
9. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
10. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
11. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
12. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
13. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____

**SECTION C - TOTAL**

14. TOTAL LEASE EXPENSE ON OPERATING LEASES AND NON-CAPITALIZED LEASES \$-

### SCHEDULE 36A: Capitalized Leases

#### SECTION A - CAPITALIZED LEASE INFORMATION

#### Lease Expense

1. Name of lessor \_\_\_\_\_  
 Is lessor a related party? . . . . .  Yes  No  
 Beginning Lease Date \_\_\_\_\_  
 Ending Lease Date \_\_\_\_\_  
 Is this a lease purchase agreement?  Yes  No  
 Description of leased property \_\_\_\_\_

1a. Amortization of capitalized lease value \_\_\_\_\_  
 1b. Interest expense on capital lease obligation \_\_\_\_\_  
 1c. Accrued contingent lease payments for period . . . \_\_\_\_\_  
 1d. SUBTOTAL LEASE EXPENSE \_\_\_\_\_

2. Name of lessor \_\_\_\_\_  
 Is lessor a related party? . . . . .  Yes  No  
 Beginning Lease Date \_\_\_\_\_  
 Ending Lease Date \_\_\_\_\_  
 Is this a lease purchase agreement?  Yes  No  
 Description of leased property \_\_\_\_\_

2a. Amortization of capitalized lease value \_\_\_\_\_  
 2b. Interest expense on capital lease obligation \_\_\_\_\_  
 2c. Accrued contingent lease payments for period . . . \_\_\_\_\_  
 2d. SUBTOTAL LEASE EXPENSE \_\_\_\_\_

3. Name of lessor \_\_\_\_\_  
 Is lessor a related party? . . . . .  Yes  No  
 Beginning Lease Date \_\_\_\_\_  
 Ending Lease Date \_\_\_\_\_  
 Is this a lease purchase agreement?  Yes  No  
 Description of leased property \_\_\_\_\_

3a. Amortization of capitalized lease value \_\_\_\_\_  
 3b. Interest expense on capital lease obligation \_\_\_\_\_  
 3c. Accrued contingent lease payments for period . . . \_\_\_\_\_  
 3d. SUBTOTAL LEASE EXPENSE \_\_\_\_\_

4. Name of lessor \_\_\_\_\_  
 Is lessor a related party? . . . . .  Yes  No  
 Beginning Lease Date \_\_\_\_\_  
 Ending Lease Date \_\_\_\_\_  
 Is this a lease purchase agreement?  Yes  No  
 Description of leased property \_\_\_\_\_

4a. Amortization of capitalized lease value \_\_\_\_\_  
 4b. Interest expense on capital lease obligation \_\_\_\_\_  
 4c. Accrued contingent lease payments for period . . . \_\_\_\_\_  
 4d. SUBTOTAL LEASE EXPENSE \_\_\_\_\_

5. **TOTAL CAPITALIZED LEASE EXPENSE FOR REPORTING PERIOD** . . . . . **\$-**

### SCHEDULE 36B: Capitalized Leases

#### SECTION B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

A1. Name of lessor \_\_\_\_\_

A3. Are any capitalized costs reported on other schedules? .....  Yes  No

B1. Name of lessor \_\_\_\_\_

B3. Are any capitalized costs reported on other schedules? .....  Yes  No

C1. Name of lessor \_\_\_\_\_

C3. Are any capitalized costs reported on other schedules? .....  Yes  No

D1. Name of lessor \_\_\_\_\_

D3. Are any capitalized costs reported on other schedules? .....  Yes  No

A2. Actual payments required by lease in report period . . . . . \_\_\_\_\_

A4. If yes, (schedule) \_\_\_\_\_ (line) \_\_\_\_\_ (amount) \_\_\_\_\_

B2. Actual payments required by lease in report period . . . . . \_\_\_\_\_

B4. If yes, (schedule) \_\_\_\_\_ (line) \_\_\_\_\_ (amount) \_\_\_\_\_

C2. Actual payments required by lease in report period . . . . . \_\_\_\_\_

C4. If yes, (schedule) \_\_\_\_\_ (line) \_\_\_\_\_ (amount) \_\_\_\_\_

D2. Actual payments required by lease in report period . . . . . \_\_\_\_\_

D4. If yes, (schedule) \_\_\_\_\_ (line) \_\_\_\_\_ (amount) \_\_\_\_\_

**E. TOTAL CAPITALIZED LEASE PAYMENTS RELATED TO CAPITALIZED LEASES** ..... **\_\_\_\_\_ \$-**

### SCHEDULE 37: Property Taxes

**SECTION A - FOR ALL PROVIDERS**

Expense

1. 2020 Real Estate Tax Bill

2. 2020 Personal Property Tax Bill

3a. Have the amounts reported on lines 1 and 2 been paid in full?  Yes, go to question 3b  No, explain below

Date(s) paid \_\_\_\_\_ Amount(s) paid \_\_\_\_\_ Amount still outstanding \_\_\_\_\_

3b. Are there any real estate or personal property tax still outstanding from prior years, eg. 2018 or 2019?  Yes, explain below  No

Tax year \_\_\_\_\_ Amount still outstanding \_\_\_\_\_ Tax year \_\_\_\_\_ Amount still outstanding \_\_\_\_\_

**SECTION B - FOR TAX-EXEMPT PROVIDERS ONLY**

Expense

4. 2020 Municipal Service Fee or Payment in Lieu of Taxes

5. Identify where municipal service fee expenses are reported in the cost report if not above on this schedule.

Cost center name \_\_\_\_\_ Schedule number \_\_\_\_\_ Line number \_\_\_\_\_ Amount reported \_\_\_\_\_

6. Describe the services provided by the municipality for the above fees. \_\_\_\_\_

**7. TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE** ..... \$-

### SCHEDULE 37RP: Related Party Property Taxes

**SECTION A - FOR ALL PROVIDERS**

- 1. 2020 Real Estate Tax Bill
- 2. 2020 Personal Property Tax Bill

**Expense**

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3a. Have the amounts reported on lines 1 and 2 been paid in full?  Yes, go to question 3b  No, explain below

Date(s) paid \_\_\_\_\_ Amount(s) paid \_\_\_\_\_ Amount still outstanding \_\_\_\_\_

3b. Are there any real estate or personal property tax still outstanding from prior years, eg. 2018 or 2019?  Yes, explain below  No

Tax year \_\_\_\_\_ Amount still outstanding \_\_\_\_\_ Tax year \_\_\_\_\_ Amount still outstanding \_\_\_\_\_

**SECTION B - FOR TAX-EXEMPT PROVIDERS ONLY**

- 4. 2020 Municipal Service Fee or Payment in Lieu of Taxes
- 5. Identify where municipal service fee expenses are reported in the cost report if not above on this schedule.

**Expense**

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Cost center name \_\_\_\_\_ Schedule number \_\_\_\_\_ Line number \_\_\_\_\_ Amount reported \_\_\_\_\_

6. Describe the services provided by the municipality for the above fees. \_\_\_\_\_

**TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE** ..... **\$-**

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**SCHEDULE 38 - NO LONGER USED**

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**SCHEDULE 39 - NO LONGER USED**

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**NURSING HOME COST REPORT SCHEDULES 38, 39**

**SCHEDULE 40: Allocated Property Expenses**

	Areas for Non-NH Serv. Or Other Major Revenue-Generating Activities								
	A. Total From Sched.	B. NH Service Area	C. Hospital			D. CBRF		E. Other	
			Hospital	CBRF	Other	CBRF	Other		
<b>SECTION A - DIRECT PROPERTY EXP.</b>									
1. Property insurance (s31)	\$18,099								
2. Mortgage insurance (s31)	-								
3. Amortization debt premium discount (s32)	-								
4. Plant asset interest expense (s33)	336,536								
5. Depreciation land improvements (s34)	31,622								
6. Depreciation buildings (s34)	461,319								
7. Depreciation leasehold improve. (s34)	-								
8. Depreciation fixed equipment (s34)	-								
9. Depreciation moveable equip. (s34)	13,773								
10. Depreciation transportation veh. (s34)	-								
11. Depreciation other (s34)	8,245								
12. Expense on operating leases (s35)	-								
13. Expense on capitalized leases (s36)	-								
14. Property taxes or fees (s37)	-								
15. TOTAL EXPENSE	\$869,594	\$-							
16. Less total directly assigned property exp.	\$-								
17. <b>NET UNASSIGNED/INDIRECT PROP. . . . .</b>	<b>\$869,594</b>								
<b>SECTION B - NON-SALARY EXPENSES</b>									
18. Square feet of service's building area	102,153	70,817	12,419	6,960	11,957				
19. Ratio to total square feet to 4 decimals	1.0000	0.6932	0.1216	0.0681	0.1170				
20. Indirect property expense allocation	\$869,594 (from 17A)	602,803 20A x 19B	105,743 20A x 19C	59,219 20A x 19D	101,742 20A x 19E				
<b>SECTION C - TOTAL</b>									
21. <b>TOTAL PROP. EXP. FOR EACH AREA</b>	<b>\$869,507</b> 17A + 20 A	<b>\$602,803</b> 15B + 20B	<b>\$105,743</b> 15C + 20C	<b>\$59,219</b> 15D + 20D	<b>\$101,742</b> 15E + 20E				



### SCHEDULE 41: Paid Time-Off Expenses

**SECTION A - POLICIES AND PRACTICES**

1. Accounting method - expenses are to be reported on the accrual method of accounting except for governmental facilities, which may use the cash method. Check the accounting method used in this cost report.

Accrual

Cash

2. Capitalization of plant assets - briefly describe the facility's policy or practice for the capitalization of plant assets purchases. Items over \$5000 are capitalized over their useful life. For this cost report items for the nursing home over \$1000 are Capitalized

3. Volunteer and unpaid employees - briefly explain if and how volunteer and other unpaid employee hours are reported in this cost report  
Minimal Amount. Not accounted for on this report.

4. Conformity - describe any accounting practices/policies in reporting revenues and expenses which are known to NOT conform to generally accepted accounting principles.  
None.

**SECTION B - NON-PRODUCTIVE SALARY EXPENSE AND HOURS**

Type of Paid Time-Off	A. Based on Actual or Earned Time-Off?		B. Are Reported Amounts an Estimate?	
	Actual	Earned	Yes	No
1. Vacation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Holidays	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Sick time	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Break, meal time	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Holiday premium	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. In-service training	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SCHEDULE 42: Identification of Expenses from Transactions with Related Parties and Organizations**

**SECTION A - RELATED PARTY LEASES**

Location and Amount of Expense Included in This Cost Report

<u>A. Description of Expense Item</u>	<u>B. Cost Ctr.</u>	<u>C. Schedule</u>	<u>D. Column</u>	<u>E. Line</u>	<u>F. Net Expense</u>
1. Total related party lease expense					
2. Insurance expense					
3. Amortization deferred expense					
4. Interest expense					
5. Depreciation expense					
6. Property tax expense					
7. _____					
8. _____					
9. SUBTOTAL FOR RELATED PARTY LEASES					\$-

**SECTION B - OTHER RELATED PARTY TRANSACTIONS**

10. _____					
11. _____					
12. _____					
13. _____					
14. _____					
15. TOTAL AMOUNT TO ADJUST RELATED PARTY TRANSACTIONS TO COST (to schedule 11, line 18) . . . . .					\$-

**SECTION C - IDENTIFICATION OF RELATED PARTIES**

16. List the name and location of the related parties with whom the nursing home provider has transacted business with during the cost report period.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SCHEDULE 43: Identification of Expenses Not Related to Patient Care**

A. Description of Expense Item	Amount	Cost Ctr.	Location of Expense in Cost Report		
			Schedule	Column	Line
1. Promotional expenses					
2. Gifts and flowers					
3. Personal expenses of owners					
4. Entertainment for non-residents					
5. Telephone, television, internet and cable service in resident rooms					
6. Contributions and donations					
7. Fines and penalties					
8. Interest expense on non-care working capital loans					
9. Interest expense on non-care plant asset loans					
10. Non-care related membership fees					
11. Training programs for non-employees					
12. Special legal and professional fees					
13. Owner or key person life insurance					
14. Taxes					
15. Fund raising expenses					
16. Excess property					
17. Out of State Travel (Destination)					
18. Gift, flower, or coffee shops and snack counters					
19. Reorganization, stockholder, or stock purchase expenses					
20. Goodwill and Abandoned Planning Expenses					
21. Other - describe: _____					
22. Other - describe: _____					

**SCHEDULE 43A - NO LONGER USED**

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**SCHEDULE 44 - NO LONGER USED**

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**SCHEDULE 45: Distribution of Compensation Expenses to Key Personnel  
Submit as a separate supporting document.**

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**SCHEDULE 46: Identification of Expenses for Employee Unique Fringe Benefits**

<u>A. Name of Employee</u>	<u>B. Title</u>	<u>C. Describe Unique Fringe Benefit Item</u>	<u>D. Cost Ctr. Salary Exp.</u>	<u>E. Cost Ctr. Benefit Exp.</u>	<u>F. Schedule</u>	<u>G. Column</u>	<u>H. Line</u>	<u>I. Benefit Expense Amount</u>
1. _____	_____	_____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____	_____	_____	_____	_____
15. _____	_____	_____	_____	_____	_____	_____	_____	_____
16. _____	_____	_____	_____	_____	_____	_____	_____	_____

**SCHEDULE 49: Percentage of Ownership**

	Name of Individual or Entity	Percentage of Ownership
1.	County of Brown, WI	100%
2.		
3.		
4.		
5.		

**SCHEDULE 50: Interest in Other Providers**

	Name and City of Medicaid Provider	Type of Medical Services Provided	Nature and Extent of Interest in Provider
1.	BCCTC-Nicolet Hospital	Psychiatric Hospital	Shared Facility
2.	BCCTC-Bayhaven CBRF	Crisis CBRF	Shared Facility
3.			
4.			
5.			

**SCHEDULE 51 - NO LONGER USED**

**SCHEDULE 52: Miscellaneous Medicaid Non-Rate Revenues**

<b>Medicaid Revenue Item</b>	<b>Revenue Amount</b>	<b>Location in Cost Report</b>	
		<b>Schedule</b>	<b>Line</b>
1. Personalized durable medical equipment including Clinitron beds and motorized wheelchairs.....			
2. Specialized services for the mentally ill.....	31,644	15	13
3a. Nurse aide training and competency evaluations - revenues from training aides for other facilities.....			
3b. Nurse aide training and competency evaluations - revenues from training aides for your own facilities.....			
3c. Nurse aide training and competency evaluations - revenues for performing competency evaluations.....			
<b>4. TOTAL MISCELLANEOUS MEDICAID NON-RATE REVENUES .....</b>	<b>\$31,644</b>		

**SCHEDULE 53: Incentives – Private Room & Property**

**SECTION A - PRIVATE ROOM INCENTIVE**

Indicate if your facility is requesting a private room incentive

Yes, my facility is requesting the private room incentive.

<b>AFFIDAVIT</b>		
I HEREBY ATTEST and affirm that from July 1, 2021, to June 30, 2022, the <u>Brown County Community Treatment Center</u>		
nursing home will not charge/has not charged Medicaid residents any amount for private rooms including but not limited to the surcharge as provided under Ch DHS 107.09(4)(k), Wis. Admin. Rules. I furthermore acknowledge that all payments the facility has received for the Medicaid Private Room Incentive may be recouped retroactive to July 1, 2021, if the facility has charged Medicaid residents for private rooms during this period.		
<b>SIGNATURE -</b>	Original Signature of Officer or Administrator of Nursing Home	Title
Date		

**SECTION B - PROPERTY INCENTIVE**

1. Did the facility get approval for the Innovative Area Incentive prior to 7/1/12?

YES

2. Did the facility get approval for the Innovative Area Incentive on or after 7/1/12?

YES