# WISCONSIN MEDICAID PROGRAM 2019 NURSING HOME COST REPORT

Completion of this form is required by Section 1.171 of the Methods of Implementation for Wisconsin Medicaid Nursing Home Payment Rates (Methods). Failure to complete and submit this form by the due date may result in a reduction or forfeiture of the payment rate, as provided in Section 49.45(13), Wis. Stats.

## SCHEDULE 1 - FACILITY AND PREPARER INFORMATION AND CERTIFICATION

### SECTION A - FACILITY INFORMATION

| Facility Name | Main Telephone Number | Main E-Mail Address | |
|---|---|---|---|
| The Pavilion at Glacier Valley | (262) 297-6300 | Dawn.Gordon@fundltc.com | |
| **Facility Street Address** | **City** | **State** | **Zip Code** |
| 1900 American Eagle Drive | Slinger | WI | 53086 |

| Contact Person | Contact Telephone Number | Contact E-Mail Address | Corporate Facility Number |
|---|---|---|---|
| Jennifer Johnson | (410) 773-5794 | jen.johnson@fundltc.com | |

| Cost Report Period Start Date | Cost Report Period End Date | Medicaid Provider Number | National Provider Identifier (NPI) | POP ID Number |
|---|---|---|---|---|
| 1/1/2019 | 12/31/2019 | 20191500 | 1407943681 | 371 |

| Administrator | Chief Financial Officer | Where are the financial records of the nursing home located? |
|---|---|---|
| Dawn Gordon | Denise Jones | 920 Ridgebrook Road Sparks, MD 21152 |

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

| Name and Title | | Telephone Number | |
|---|---|---|---|
| Jennifer Johnson Reimbursement Analyst | | 410-773-5794 | |
| **Address** | **City** | **State** | **Zip Code** |
| 920 Ridgebrook Road | Sparks | MD | 21152 |
| 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'S NOTES, COMMENTS AND QUALIFICATIONS REGARDING THE MEDICAID NURSING HOME COST REPORT

**INSTRUCTIONS:** This schedule may be used by the nursing home administrator, owners, officers and cost report preparers to provide notes, comments or qualifications regarding the financial and statistical data reported in the accompanying cost report. Attach additional sheets if necessary.

| Commentator's Name | Title | Date |
|---|---|---|
| | | |

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# SCHEDULE 3 - GENERAL INFORMATION

1. Type of Medicaid certification (check all that apply) — [X] (01) Nursing Facility; [ ] (10) ICF-IID

2. Type of license (check all that apply) — [X] (01) Skilled Nursing; [ ] (20) Developmentally Disabled; [ ] (10) Intermediate Care; [ ] (40) IMD

3. Type of ownership (check one) — [X] (1) Proprietary; [ ] (2) Voluntary Non-Profit; [ ] (3) Governmental

4. County of facility: Washington — County Code: 66

5. Does the facility self-fund any of the fringe benefits reported on schedule 28? If yes, provide documentation to support the amount claimed. — [X] (1) Yes [ ] (2) No

6. Does the facility provide laundry services to residents for personal clothing? — [X] (1) Yes [ ] (2) No

7. Are any employees of the facility covered by a union contract? — [X] (1) Yes [ ] (2) No

8. Is the facility Medicare (Title XVIII) certified? — [X] (1) Yes [ ] (2) No

9. Fiscal Year Beginning Month: Jan — Fiscal Year Ending Month: Dec

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

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.

| | DATE | BEDS |
|---|---|---|
| Beds at Beginning of Cost Reporting Period | 1/1/2019 | 106 |
| Beds at End of Cost Reporting Period | 12/31/2019 | 106 |
| | | |
| | | |

11. 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 [X] (2) No

12. 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; [X] (4) Other related party transactions

13A. 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? — [X] Yes [ ] No

13B. Asset depreciation schedules detailing amounts reported on Schedule 34 - Depreciation expenses must be submitted. Have copies been made and included with this cost report? — [X] Yes [ ] No

**14. 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. | The Pavilion at Glacier Valley | 3232 | 46 | 60 | 106 |
| 2. | | | | | - |
| 3. | | | | | - |
| 4. | TOTAL | | 46 | 60 | 106 |

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# SCHEDULE 4 - MAJOR REVENUE GENERATING ACTIVITIES

| **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: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Hospital, Name of hospital:<br>Beds at end of cost report period: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Non-Medicaid NH unit or structure, Beds at end of cost report period: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Non-Medicaid CBRF, Beds at end of cost report period: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Room and board unit or structure, Beds at end of cost report period: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Apartment units, Units at end of cost report period: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. School, Describe:<br>Does school serve students under 21? ☐ Yes ☐ No | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Outpatient mental health clinic | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Contract with county mental health/disability board for special services to NH patients, Describe: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Therapy services, Describe: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Pharmacy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Laboratory or radiology services | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Rental of building space | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. Elderly or other day care | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Elderly home care | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. Fund raising activities | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. Farm | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18. Food catering services (meals on wheels, etc.) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19. Child care | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20. Clinic | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21. Other, Describe: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22. Any items checked in Columns L - AG? 1 = Yes 0 = No | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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# SCHEDULE 5 - BUILDING SQUARE FOOTAGE

| SECTION A - GENERAL INFORMATION | WING A | WING B | WING C | WING D |
|---|---|---|---|---|
| Name or description of building or wing | SNF | | | |
| Year construction was functionally completed on building or wing | 2012 | | | |
| Total square footage of building or wing | 51,752 | | | |
| **SECTION B - NURSING HOME SERVICE AREAS** | | | | |
| 1. Nuns or other employees' housing | | | | |
| 2. Employees' unique fringe benefit areas | 417 | | | |
| 3. Dietary (kitchen, food preparation & storage, dish washing, kitchen cleanup) | 5,193 | | | |
| 4. Plant equipment (furnace/boiler room, electrical, water, similar plant equip.) | 783 | | | |
| 5. Laundry (washing/drying room, sorting/folding rooms, central linen storage) | 761 | | | |
| 6. Administration (general/accounting offices, reception areas, meeting rooms) | 1,563 | | | |
| 7. Laboratory & radiology | - | | | |
| 8. Pharmacy | 256 | | | |
| 9. Physical therapy | 1,513 | | | |
| 10. Occupational therapy | 1,453 | | | |
| 11. Other therapies | 363 | | | |
| 12. Beauty and barber shops | 251 | | | |
| 13. Gift shop, canteen, snack shop | - | | | |
| 14. Patient areas (rooms, bathrooms, halls, nurse desk/office, dayrooms, rec.) | 22,097 | | | |
| **SECTION C - RENTED AND OTHER MAJOR REVENUE ACTIVITY AREAS (SEE SCHEDULE 4). IDENTIFY EACH ACTIVITY** | | | | |
| 15. Hospital direct patient service areas | - | | | |
| 16. Housekeeping | 386 | | | |
| 17. Social Services & Activities (not rented) | 1,067 | | | |
| 18. Central Medical Supplies, Medical Records (not rented) | 504 | | | |
| **SECTION D - OTHER AREAS** | | | | |
| 19. Major idle or closed areas | | | | |
| 20. Residual unidentified square footage (Total area less lines 1 through 19) | 15,145 | | | |

Describe general purpose or use of Line 20 square footage: Common Area

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# SCHEDULE 6 - TOTAL PATIENT DAYS

## SECTION A - INHOUSE PATIENT DAYS

| | | LEVEL OF CARE (LOC) NON DD | DD | TOTAL |
|---|---|---|---|---|
| 1a. | Medicaid (T-19) | 10,612 | - | 10,612 |
| 1b. | ICF-IID Medicaid (T-19) | - | - | - |
| 1c. | Family Care (T-19) | 5,345 | - | 5,345 |
| 1d. | Other Medicaid Managed Care (T-19) | 594 | - | 594 |
| 1e. | Hospice (T-19) | 883 | - | 883 |
| 1f. | Ventilator (T-19) | - | - | - |
| 2a. | Medicare (T-18) | 5,669 | - | 5,669 |
| 2b. | Medicare Advantage, for days covered as a Part A stay | - | - | - |
| 3a. | Private pay & Insurance | 7,541 | - | 7,541 |
| 3b. | Medicare Advantage, for days not covered as a Part A stay | 733 | - | 733 |
| 3c. | Hospice (Private pay & Insurance) | - | - | - |
| 4. | Other, Specify: Other | - | - | |
| 5. | TOTAL INHOUSE PATIENT DAYS | 31,377 | - | 31,377 |

## SECTION B - BED HOLD DAYS
**Charged Bed Hold Days Only**

| | | NON DD | DD | TOTAL |
|---|---|---|---|---|
| 6a. | Medicaid (T-19) | 15 | - | 15 |
| 6b. | ICF-IID Medicaid (T-19) | - | - | - |
| 6c. | Family Care & Partnership (T-19 | - | - | - |
| 7. | All Other | 5 | - | 5 |
| 8. | TOTAL CHARGED BED HOLD DAYS. | 20 | - | 20 |

## SECTION C - TOTAL PATIENT DAYS

| | | NON DD | DD | TOTAL |
|---|---|---|---|---|
| **9.** | **TOTAL DAYS (lines 5 + 8)** | **31,397** | **-** | **31,397** |

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## SCHEDULE 7 - NO LONGER USED

Information is now on Schedule 6

## SCHEDULE 8 - TOTAL PATIENT DAYS BY MONTH

**(Required)**

| | MONTH | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | **TOTAL** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | MONTH . . . . . | | | | | | | | | | | | | |
| 2. | Days in Month . . . . . | 31 | 28 | 31 | 30 | 31 | 30 | 31 | 31 | 30 | 31 | 30 | 31 | 365 |
| 3. | Licensed Beds for Bed Hold Testing. . . . | 106 | 106 | 106 | 106 | 106 | 106 | 106 | 106 | 106 | 106 | 106 | 106 | 1,272 |
| 4. | Occupancy Test: | | | | | | | | | | | | | |
| | Row 2 X (Row 3 X 94%) | 3,089 | 2,790 | 3,089 | 2,989 | 3,089 | 2,989 | 3,089 | 3,089 | 2,989 | 3,089 | 2,989 | 3,089 | 36,369 |
| 5. | Inhouse patient days | 2,392 | 2,334 | 2,561 | 2,735 | 2,725 | 2,554 | 2,624 | 2,681 | 2,655 | 2,769 | 2,616 | 2,731 | 31,377 |
| 6. | Bed Hold days . . . . | - | 11 | 4 | 1 | 1 | 1 | 2 | - | - | - | - | - | 20 |
| 7. | **TOTAL DAYS . . .** | 2,392 | 2,345 | 2,565 | 2,736 | 2,726 | 2,555 | 2,626 | 2,681 | 2,655 | 2,769 | 2,616 | 2,731 | 31,397 |

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 9A - HOSPICE PATIENT DAYS - NO LONGER USED

Information is now on Schedule 6

## SCHEDULE 9B - VENTILATOR DEPENDENT PATIENT DAYS - NO LONGER USED

Information is now on Schedule 6

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# SCHEDULE 10 - BALANCE SHEET

| ASSETS | Begin Date 1/1/19 | End Date 12/31/19 |
|---|---|---|
| **CURRENT ASSETS** | | |
| Cash on hand and in bank | $14,293 | $27,136 |
| Temporary investments | - | - |
| Resident accounts receivable | 1,765,626 | 1,630,568 |
| Other accounts receivable | - | 143 |
| Due from related parties | - | - |
| Notes receivable | - | - |
| Accrued interest receivable | - | - |
| Inventories | 18,285 | 18,285 |
| Prepaid expenses | (2,077) | (1,652) |
| Resident funds held in trust | - | - |
| Other current assets, list below: | | |
| Accrued Revenue | - | - |
| | | |
| | | |
| TOTAL CURRENT ASSETS | $1,796,127 | $1,674,480 |
| **PROPERTY, PLANT, EQUIP.** | | |
| Land | $- | $- |
| Land improvements | - | - |
| Buildings | - | - |
| Leasehold improvements | (99,000) | (89,119) |
| Fixed equipment | 16,683 | 17,981 |
| Moveable equipment | 367,529 | 376,926 |
| Transportation equipment | - | - |
| Other | 59,078 | 62,715 |
| Less: accumulated depreciation | ( 202,423 ) | ( 213,750 ) |
| TOTAL PROPERTY, PLANT, EQUIPMENT | $141,867 | $154,753 |
| **OTHER** | | |
| Long term investments | $- | $- |
| Other Assets, list below: | | |
| Other Non-Current Assets | 314,675 | 363,142 |
| | | |
| TOTAL OTHER ASSETS | $314,675 | $363,142 |
| **TOTAL ASSETS** | $2,252,669 | $2,192,375 |

| LIABILITIES AND OWNERS' EQUITY | Begin Date 1/1/19 | End Date 12/31/19 |
|---|---|---|
| **CURRENT LIABILITIES** | | |
| Notes and loans payable, list below: | | |
| | | |
| | | |
| | | |
| | | |
| Due to related parties | - | - |
| Accounts payable | 182,893 | 207,860 |
| Accrued salaries | 226,960 | 246,773 |
| Other accrued expenses | 387,379 | 430,548 |
| Resident trust funds payable | (2,659) | (13,804) |
| Other current liabilities | | - |
| TOTAL CURRENT LIABILITIES | $794,573 | $871,377 |
| **LONG TERM LIAB.** | | |
| Notes and loans payable (list) below: | | |
| FAS Straight Line Rent | 668,081 | 676,781 |
| Intercompany Balance | 3,549,547 | 3,469,008 |
| Other long term liabilities | | |
| TOTAL LONG TERM LIABILITIES | $4,217,628 | $4,145,789 |
| **OWNER EQUITY** | | |
| OWNERS' EQUITY, list below: | | |
| KPMG Audit Adjustment | (19,012) | - |
| Retained Earnings | (2,790,039) | (2,759,532) |
| Current Year earnings per books | 49,519 | (65,259) |
| TOTAL OWNER'S EQUITY | $(2,759,532) | $(2,824,791) |
| **TOTAL LIABILITIES AND EQUITY** | $2,252,669 | $2,192,375 |

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# SCHEDULE 10A - SUMMARY OF CHANGES IN OWNERS' EQUITY

| | | | | |
|---|---|---|---|---|
| 1. | Beginning Owners' Equity (from schedule 10) | | | $(2,759,532) |
| 2. | Add | Net income (from schedule 11, line 21) | $- | |
| | | Owners' capital contribution | | |
| | | County appropriation | | |
| | | Net decrease in accrued vacation, holiday and sick time | | |
| | | Other, Specify: | | |
| | | Other, Specify: | | |
| | | Total additions | | - |
| 3. | Deduct | Net loss (from schedule 11, line 19) | ($140,033) | |
| | | Dividends and withdrawals | ( ) | |
| | | Net increase in accrued vacation, holiday and sick time | ( ) | |
| | | Other, Specify: Rounding | (3) | |
| | | Other, Specify: Before Cost Report Adjustment | (74,777) | |
| | | Total deductions | | (65,259) |
| **4.** | **ENDING OWNERS' EQUITY (schedule 10).** | | | $(2,824,791) |

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# SCHEDULE 11 - SUMMARY OF REVENUES AND EXPENSES

All values are automatically posted from other schedules.

**SECTION A - SUMMARY OF REVENUE**

| | | | |
|---|---|---|---|
| 1. | Daily patient service revenue | schedule 14, lines 1-4 | $ 9,308,028 |
| 2. | Service fees | schedule 15, line 14A | 359,711 |
| 3. | Rent from outside medical providers | schedule 15, line 14B | - |
| 4. | Other | schedule 15, line 14C | - |
| 5. | Dietary revenues | schedule 16, line 5A | - |
| 6. | Miscellaneous services and materials revenue | schedule 16, line 16 | - |
| 7. | Rental revenues | schedule 17, line 21A | - |
| 8. | Revenues from other major activities | schedule 17, line 37 | - |
| 9. | Sales to related organizations | schedule 18, line 41 | - |
| 10. | Investment revenue | schedule 18, line 45 | - |
| 11. | Gains (Losses) on disposal of assets | schedule 18, line 47 | - |
| 12. | Grants for government-subsidized employees | schedule 18, line 48 | - |
| 13. | Grants, contributions, donations | schedule 18, line 49 | - |
| 14. | Other revenue | schedule 18, line 54 | 29,211 |
| 15. | Subtract: deductions from revenues | schedule 14, line 5 | ( (591,627) ) |
| 16. | NET REVENUES | | $ 10,288,577 |

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

| | | | |
|---|---|---|---|
| 17. | Subtract: total expenses | schedule 12, line 38 | $ ( 10,428,610 ) |
| 18. | Add or subtract the amount to adjust related party transactions to cost | schedule 42, line 15 | - |
| **19.** | **NET INCOME OR LOSS** | | $ **(140,033)** |

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# SCHEDULE 12 - SUMMARY OF TOTAL EXPENSES

All values are automatically posted from other schedules.

| Cost Center | Reference | Expense |
|---|---|---|
| 1. Daily patient service expense | S20, L10 | $3,503,462 |
| 2. Laboratory & Radiology | S21, L15a | 52,195 |
| 3. Respiratory | S21, L15b | - |
| 4. Pharmacy | S21, L15c | 277,134 |
| 5. PT, OT and Speech | S22, L15a | 965,469 |
| 6. Dental | S22, L15b | - |
| 7. Physician | S22, L15c | 21,000 |
| 8. Social Services | S23, L15a | 92,229 |
| 9. Recreational Activities | S23, L15b | 66,180 |
| 10. Religious Services | S23, L15c | - |
| 11. Volunteer Coordinator | S24, L15a | - |
| 12. Ward Clerks | S24, L15b | 26,584 |
| 13. Psychotherapy | S24, L15c | 8,375 |
| 14. Other | S24, L15d | 6,600 |
| 15. Dietary | S25, L19a | 498,368 |
| 16. Plant Operations and Maintenance | S25, L19b | 190,556 |
| 17. Housekeeping | S25, L19c | 131,384 |
| 18. Laundry and Linen | S25, L19d | 92,603 |
| 19. Security | S25, L19e | - |

| Cost Center | Reference | Expense |
|---|---|---|
| 20. Transportation | S25, L19f | $7,714 |
| 21. Administrative service expense | S26, L12 | 1,214,405 |
| Other cost centers, Specify: | | |
| 22. Nurse Aide Training | S27, L15a | |
| 23. Beauty/Barber Shop | S27, L15b | |
| 24. 0 | S27, L15c | |
| 25. 0 | S27, L15d | |
| 26. 0 | S27, L15e | |
| UNASSIGNED EXPENSES | | |
| 27. Employee fringe benefit expense | S28, L17 | 1,058,421 |
| 28. Heating fuel and utility expense | S29, L10 | 184,165 |
| 29. Interest on operating working capital loans | S30, L6 | - |
| 30. Insurance expense | S31, L9 | 35,480 |
| 31. Amortization expense | S32, L5 | - |
| 32. Interest on plant asset loans | S33, L15h | - |
| 33. Depreciation expense | S34, L20c | 39,793 |
| 34. Expense on operating and non-cap.leases | S35, L14 | 1,753,327 |
| 35. Expense on capitalized leases | S36A, L5 | - |
| 36. Property tax expense | S37, L9 | 203,166 |
| 37. Other non-salary expense | S39, L4 | - |
| **38. TOTAL EXPENSES FOR REPORT PERIOD (Sum 1-38).** | | $10,428,610 |

(To schedule 11, line 17)

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# SCHEDULE 13 - SUMMARY OF SALARY AND WAGE EXPENSES

All values are automatically posted from other schedules.

| Cost Center and Schedule | | Total Salary and Wage Expense (Line 1 or 5) | Cost Center and Schedule | | Total Salary and Wage Expense (Line 1 or 5) |
|---|---|---|---|---|---|
| Daily patient service | S20, L1e | $2,618,986 | Dietary | S25, L1a | 270,076 |
| Laboratory & Radiology | S21, L1a | - | Plant operation / maintenance | S25, L1b | 72,301 |
| Respiratory | S21, L1b & 3b | - | Housekeeping | S25, L1c | - |
| Pharmacy | S21, L1c & 3c | - | Laundry and Linen | S25, L1d | - |
| PT, OT and Speech | S22, L1a &3a | - | Security | S25, L1e | - |
| Dental | S22, L1b &3b | - | Transportation | S25, L1f | 7,714 |
| Physician | S22, L1c &3c | - | Administrative service | S26, L1e | 356,696 |
| Social Services | S23, L3a | 92,229 | Nurse aide training | S27, L1a | - |
| Recreational Activities | S23, L3b | 57,298 | Beauty and barber | S27, L1b | - |
| Religious Services | S23, L3c | - | Other, Specify: 0 | S27, L1c | - |
| Volunteer Coordinator | S24, L1a & 3a | - | 0 | | - |
| Ward Clerks | S24, L1b & 3b | 26,584 | 0 | | - |
| Psychotherapy | S24, L1c & 3c | - | **TOTAL SALARY AND WAGE EXPENSE** | | $3,501,884 |
| Other | S24, L1d & 3d | - | | | |

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# SCHEDULE 14 - DAILY PATIENT SERVICE REVENUES

**INSTRUCTIONS:** If a facility has received its retroactive Medicaid rate adjustment, the adjusted revenues should be included in line 2 for the months of service in the cost reporting period. Some facilities may have not received the retroactive Medicaid rate adjustments due to them for services provided during the months of the cost reporting period.

| **SECTION A - DAILY RATE CHARGES** | **Revenue** |
|---|---|
| 1. Medicare Daily Rate | $1,743,400 |
| 2. Medicaid Daily Rate (including bed hold) | 4,888,320 |
| 3. Private Pay | 2,651,102 |
| 4. Medical Supplies,Other | 25,206 |
| **SECTION B - Deductions From Revenue** | |
| 5. TOTAL DEDUCTIONS FROM REVENUE | ( (591,627) ) |
| **SECTION C - TOTAL** | |
| 6. TOTAL DAILY PATIENT SERVICE REVENUE | $9,899,655 |

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

- [ ] Yes, all significant retroactive Medicaid rate adjustments are included.
- [x] 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 $296.35
8. Facility Comment (Optional)

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# SCHEDULE 15 - SPECIAL SERVICE REVENUES

**INSTRUCTIONS:** Refer to schedules 25A, 25B, 26B, 29, and 40 and their instructions regarding the allocation of general services and property expenses to those building areas which are used for providing the revenue generating services or which are rented out for those services. If applicable, administrative service expenses must be allocated to the revenue generating service.

For Column B (Rent Revenue), describe the rental fee basis (example: rent per month, percent of charges) and the services, equipment, and square feet of space furnished to the outside provider. Add additional sheets if necessary.

## SECTION A - SERVICE REVENUES

| | | A. Service Fee Charges | B. Rent from Outside Medical Providers | C. From Other Sources | Describe Other |
|---|---|---|---|---|---|
| 1. | Laboratory | $26,750 | | | |
| 2. | Radiology | 3,000 | | | |
| 3. | Pharmacy | 455,745 | | | |
| 4. | Physical therapy | 1,817,600 | | | |
| 5. | Speech/hearing therapy | 1,353,239 | | | |
| 6. | Occupational therapy | 1,895,685 | | | |
| 7. | Physician care | - | | | |
| 8. | Psychotherapy | - | | | |
| 9. | Respiratory therapy | - | | | |
| 10. | Social services | - | | | |
| 11. | Recreational activities | - | | | |
| 12. | Special duty nursing | - | | | |
| 13. | Other, Specify: Equip, Telemetry, Contra | (5,192,308) | | | |
| 14. | TOTAL SPECIAL SERVICE REVENUE . . If totals exceed $4,000, see instructions above. | $359,711 | $- | $- | |

## SECTION B - THERAPY REVENUES

15. Are physical, occupational, or speech therapy services provided by staff, assistants, contractors, or consultants IN SPACE AT YOUR FACILITY? [X] Yes [ ] No

16. Total gross billings for physical, occupational, and speech therapy services provided at your facility during the cost report period $5,066,524
Provide the total regardless of who provides the services, who bills for the services, or who receives the services (residents vs. non-residents).

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) $5,066,524

18. If there is any variance between the totals reported on lines 16 and 17, explain.

| | | | | | | |
|---|---|---|---|---|---|---|
| 19. | Are therapy services provided to individuals in addition to your nursing home residents? | [ ] Yes | [X] No | If yes, amount of revenue | |
| 20. | Does your facility or related organization bill Medicare Part B for therapy services at your facility? | [X] Yes | [ ] No | If yes, amount of revenue | $412,850 |
| 21. | Did you charge rent to a rehabilitation agency or independent contractor? | [ ] Yes | [X] No | If yes, amount of revenue | |

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# 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) | | | |
| 4. | Meals On Wheels | | | |
| 5. | Other Meals Sold | | | |
| **5a.** | **TOTAL DIETARY REVENUE** | **$-** | | |

## SECTION B - MISCELLANEOUS SERVICES AND MATERIALS

| | | | Expenses Directly Ascribable To Or Identifiable With Revenue | | | |
|---|---|---|---|---|---|---|
| | | Revenue | 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 | | | | | |
| 12. | Vending machines | | | | | |
| 13. | Sale of clothing | | | | | |
| 14. | Television and cable service | | | | | |
| 15. | Telephone and Internet | | | | | |
| **16.** | **TOTAL MISCELLANEOUS SERVICES AND MATERIALS** | **$-** | | | | |

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# SCHEDULE 17 - OTHER REVENUES

**INSTRUCTIONS:** For Section C, refer to schedules 25A, 25B, 29 and 40 and their instructions regarding the allocation of expenses to rented equipment or building space. For section D, only report revenues if the direct expenses and the shared and indirect expenses associated with the revenue activity are reported in this cost report. See schedule 4 or Section 700 of the instructions for more details on the reporting of expenses.

| SECTION C - RENTAL REVENUE | Revenue | Property Rented | Square Feet Rented | Services Provided |
|---|---|---|---|---|
| 18. Equipment rental | | | | |
| 19. Rental of nursing home space | | | | |
| 20. Rental of non-nursing home space | | | | |
| 21. Parking | | | | |
| **21a. TOTAL RENTAL REVENUES** | **$-** | | | |

| SECTION D - REVENUE FROM MAJOR ACTIVITIES | Revenue | Total Billable Patient Days if revenue generated from activities 24,25,26 |
|---|---|---|
| 22. Another Medicaid nursing home provider | | |
| 23. Hospital | | |
| 24. A non-Medicaid nursing home unit | | |
| 25. A non-Medicaid residential facility (CBRF) | | |
| 26. Room and board unit or structure | | |
| 27. Apartment Units | | |
| 28. Child Care Institution | | |
| 29. School | | |
| 30. Outpatient mental health clinic | | |
| 31. Elderly or other day care | | |
| 32. Elderly home care | | |
| 33. Farm | | |
| 34 | | |
| 35 | | |
| 36 | | |
| **37. TOTAL REVENUE FROM OTHER MAJOR ACTIVITIES** | **$-** | |

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# SCHEDULE 18 - OTHER REVENUES

| SECTION E - SALES TO RELATED ORGANIZATIONS | Revenue |
|---|---|
| 38. | |
| 39. | |
| 40. | |
| 41. TOTAL SALES TO RELATED ORGANIZATIONS | $- |

| SECTION F - INTEREST AND INVESTMENT REVENUE | Revenue |
|---|---|
| 42. Revenues from invested gift/grant funds not commingled with other funds | |
| 43. Revenue from invested funds used for current cash needs | |
| 44. Other revenue from invested funds | |
| 45. TOTAL INVESTMENT REVENUE | $- |

46. If total investment revenue exceeds $6,000, describe major investments (type, invested amount, purpose if any)

| SECTION G - GAINS (LOSSES) DISPOSAL OF ASSETS | Gain (Loss) |
|---|---|
| 47. TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS | |

| SECTION H - GRANTS FOR GOVT. SUBSIDIZED EMP. | Revenue |
|---|---|
| 48. TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES | |

| SECTION I - GRANTS, CONTRIBUTIONS, DONATIONS | Revenue |
|---|---|
| 49. TOTAL GRANTS, CONTRIBUTIONS, DONATIONS | |

| SECTION J - OTHER REVENUES | Revenue |
|---|---|
| 50. Misc Revenue | $- |
| 51. Settlement Revenues | 29,211 |
| 52. Interest Income - Patient Related | - |
| 53. | |
| 54. TOTAL OTHER REVENUES | $29,211 |

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# SCHEDULE 20 - DAILY PATIENT SERVICE EXPENSE

| SALARIES, WAGES PURCHASED SERV. | A. Registered Nurses | B. Licensed Practical Nurses | C. Nurse Aides and Assistants | D. Total Expense/Hrs. (sum A-C) |
|---|---|---|---|---|
| 1. TOTAL SALARY AND WAGE EXPENSE | $956,245 | $683,383 | $979,358 | $2,618,986 |
| 2. TOTAL SALARY AND WAGE HOURS | 25,067 hrs. | 22,702 hrs. | 58,336 hrs. | $106,105 |
| 3. EXPENSE FOR PURCHASED SERVICES | $166,317 | $23,967 | $427,249 | $617,533 |

| | |
|---|---|
| **NURSING AND INCONTINENCY SUPPLIES** | |
| 4. Catheters, Incontinency Supplies (including purchased laundry service | $37,642 |
| **OXYGEN** | |
| 5. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental | 64,991 |
| **OTHER** | |
| 6. Other medical supplies, personal comfort supplies and minor medical equipment | 133,420 |
| 7. Nonbillable over the counter (OTC) drugs for all residents (include other OTC drugs billable on drug claim forms schedule 21, line 11) | 30,890 |
| 8. | |
| 9. | |
| **10. TOTAL DAILY PATIENT SERVICE EXPENSE (Sum 1, 3, 4-9)** | **$3,503,462** |

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# SCHEDULE 21 - SPECIAL SERVICE EXPENSES

| | | TYPE OF SERVICE | | |
|---|---|---|---|---|
| **SECTION A - SALARY AND WAGES** | | **A. Laboratory & Radiology** | **B. Respiratory** | **C. Pharmacy** |
| 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 | $- | $- | $- |
| **SECTION B - PURCHASED SERVICES** | | | | |
| 6. | Expense for purchased service - Billable | $52,195 | | |
| 7. | Number of hours of purchased service - Billable (optional) | | | |
| 8. | Expense for purchased service - Non billable | $- | | |
| 9. | Number of hours of purchased service - Non billable (optional) | hrs. | | |
| **SECTION C - SUPPLY AND OTHER EXPENSE** | | | | |
| 10. | Pharmacy - legend drugs Billable | $- | $- | 277,134 |
| 11. | Pharmacy - over the counter drugs Billable | $- | $- | |
| 12. | Supply and Other | | | |
| 13. | | | | |
| 14. | | | | |
| **SECTION D - TOTAL** | | | | |
| **15.** | **TOTAL EXPENSES (Sum 5, 6, 8, 10-14)** | **$52,195** | **$-** | **$277,134** |
| **16.** | **TOTAL HOURS (Sum 2, 4, 7, 9)** | **hrs.** | **hrs.** | **hrs.** |

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# SCHEDULE 22 - SPECIAL SERVICE EXPENSES

| | | TYPE OF SERVICE | | |
|---|---|---|---|---|
| **SECTION A - SALARY AND WAGES** | | **A. Physical, Occupational And Speech Therapy** | **B. Dental** | **C. Physician** |
| 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. | | | |
| 5. | TOTAL SALARY AND WAGE EXPENSE | $- | $- | $- |
| **SECTION B - PURCHASED SERVICES** | | | | |
| 6. | Expense for purchased service - Billable | $964,844 | | |
| 7. | Number of hours of purchased service - Billable (optional) | 15,176 hrs. | | |
| 8. | Expense for purchased service - Non billable | | | $21,000 |
| 9. | Number of hours of purchased service - Non billable (optional). | | | |
| **SECTION C - SUPPLY AND OTHER EXPENSE** | | | | |
| 10. | Supplies | - | - | - |
| 11. | Outside Procedures | - | - | - |
| 12. | Rental Equipment | 625 | - | - |
| 13. | | | | |
| 14. | | | | |
| **SECTION D - TOTAL** | | | | |
| 15. | TOTAL EXPENSES (Sum 5, 6, 8, 10-14) | $965,469 | $- | $21,000 |
| 16. | TOTAL HOURS (Sum 2, 4, 7, 9) | 15,176 hrs. | hrs. | hrs. |

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# SCHEDULE 23 - SPECIAL SERVICE EXPENSES

| | | TYPE OF SERVICE | | |
|---|---|---|---|---|
| **SECTION A - SALARY AND WAGES** | | **A. Social Services** | **B. Recreational Activities** | **C. Religious Services** |
| 1. | Expense for hours worked - Billable | $- | $- | $- |
| 2. | Number of hours worked - Billable | hrs. | hrs. | hrs. |
| 3. | Expense for hours worked - Non-billable | $92,229 | $57,298 | |
| 4. | Number of hours worked - Non-billable | 3,399 hrs. | 3,629 hrs. | |
| 5. | TOTAL SALARY AND WAGE EXPENSE | $92,229 | $57,298 | $- |
| **SECTION B - PURCHASED SERVICES** | | | | |
| 6. | Expense for purchased service - Billable | $- | $- | $- |
| 7. | Number of hours of purchased service - Billable (optional) | hrs. | hrs. | hrs. |
| 8. | Expense for purchased service - Non billable | $- | $7,471 | |
| 9. | Number of hours of purchased service - Non billable (optional) | hrs. | | |
| **SECTION C - SUPPLY AND OTHER EXPENSE** | | | | |
| 10. | Supplies | $- | $1,411 | $- |
| 11. | Minor Furniture - Fixtures & Equipmental Rental | - | - | - |
| 12. | | | | |
| 13. | | | | |
| 14. | | | | |
| **SECTION D - TOTAL** | | | | |
| **15.** | **TOTAL EXPENSES (Sum 5, 6, 8, 10-14)** | **$92,229** | **$66,180** | **$-** |
| **16.** | **TOTAL HOURS (Sum 2, 4, 7, 9)** | **3,399 hrs.** | **3,629 hrs.** | **hrs.** |

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# SCHEDULE 24 - OTHER TYPES OF SPECIAL SERVICE EXPENSES

| | | TYPE OF SERVICE | | | |
|---|---|---|---|---|---|
| **SECTION A - SALARY AND WAGES** | | **A. Volunteer Coord.** | **B. Ward Clerks** | **C. Psychotherapy** | **D. Other** |
| 1. | Expense for hours worked - Billable | $- | $- | $- | $- |
| 2. | Number of hours worked - Billable | hrs. | hrs. | hrs. | hrs. |
| 3. | Expense for hours worked - Non-billable | $- | $26,584 | $- | $- |
| 4. | Number of hours worked - Non-billable | hrs. | 1,657 hrs. | hrs. | hrs. |
| 5. | TOTAL SALARY AND WAGE EXPENSE | $- | $26,584 | $- | $- |
| **SECTION B - PURCHASED SERVICES** | | | | | |
| 6. | Expense for purchased service - Billable | $- | $- | $- | $- |
| 7. | Number of hours of purchased service - Billable (optional) | hrs. | hrs. | hrs. | hrs. |
| 8. | Expense for purchased service - Non billable | $- | $- | $8,375 | $- |
| 9. | Number of hours of purchased service - Non billable (optional) | hrs. | hrs. | hrs. | hrs. |
| **SECTION C - SUPPLY AND OTHER EXPENSE** | | | | | |
| 10. | Legend Drugs | $- | $- | $- | $- |
| 11. | OTC Drugs | - | - | - | - |
| 12. | Supplies | - | - | - | - |
| 13. | Equipment Rental | - | - | - | 6,600 |
| 14. | | | | | |
| **SECTION D - TOTAL** | | | | | |
| **15.** | **TOTAL EXPENSES (Sum 5, 6, 8, 10-14)** | $- | $26,584 | $8,375 | $6,600 |
| **16.** | **TOTAL HOURS (Sum 2, 4, 7, 9)** | hrs. | 1,657 hrs. | hrs. | hrs. |

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# 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 | $270,076 | $72,301 | $- | $- | $- | $7,714 |
| 2. NUMBER OF HOURS WORKED | 17,962 hrs. | 3,434 hrs. | hrs. | hrs. | hrs. | 499 hrs. |
| Lines 3-5 are no longer used | | | | | | |
| **SECTION B - DIETICIAN CONSULTANT** | | | | | | |
| 6. Dietician consultant expense | | $- | $- | $- | $- | $- |
| Line 7 is no longer used | | | | | | |
| **SECTION C - OUTSIDE SERVICE** | | | | | | |
| 8. Outside Service | $8,147 | $50,466 | $129,134 | $90,908 | $- | $- |
| 9. | | | | | | |
| 10. | | | | | | |
| 11. | | | | | | |
| 12. **TOTAL OUTSIDE SERVICE EXPENSES** | $8,147 | $50,466 | $129,134 | $90,908 | $- | $- |
| **SECTION D - No longer used** | | | | | | |
| **SECTION E - SUPPLY AND OTHER EXPENSE** | | | | | | |
| 13. Supplies | $14,303 | $16,542 | $1,951 | $1,574 | $- | $- |
| 14. Food | 202,571 | - | - | - | - | - |
| 15. (B) Repairs - (A & D) Linens | 167 | 27,608 | - | 121 | - | - |
| 16. Minor Furniture -- Fixtures & Equipment | 3,104 | 13,555 | 299 | - | - | - |
| 17. Disposal | - | 10,084 | - | - | - | - |
| **SECTION F - No longer used** | | | | | | |
| **SECTION G - TOTAL** | | | | | | |
| 18. **TOTAL EXPENSES** ..... **(Sum 1, 6, 8-11, 13-17)** | **$498,368** | **$190,556** | **$131,384** | **$92,603** | **$-** | **$7,714** |

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# SCHEDULE 25A - ALLOCATION OF DIETARY AND PLANT OPERATION AND MAINTENANCE EXPENSES

## SECTION A - ALLOCATION OF DIETARY EXPENSES

| | | |
|---|---|---|
| 1. | Total dietary expenses (from schedule 25, line 18) | $498,368 |
| 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) . . . . . | $- |
| 4. | Deduct revenue (related expense) for food products sold (from schedule 16, line 2) | $- |
| 5. | NET DIETARY EXPENSES TO ALLOCATE (to line 8 A below) | $498,368 |

| | | A. Total | B. Residents' Meals | C. Employees' Meals | D. Meals on Wheels | E.Other | F. Other |
|---|---|---|---|---|---|---|---|
| 6. | Meals served | 94,131 | 94,131 | | | | |
| 7. | Ratio to total meals served to 4 decimals | 1.0000 | 1.0000 | | | | |
| 8. | DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete) | $498,368 From line 5 | $498,368 8A X 7B | $- 8A X 7C | $- 8A X 7D | $- 8A X 7E | $- 8A X 7F |

| | | |
|---|---|---|
| 9. | Food products provided to employes without charge (from line 2) | $- |
| 10. | Deduct revenue from meals sold to employees (from schedule 16, line 3) | - |
| 11. | NET EXPENSE (PROFIT) FOR MEALS AND FOOD PROVIDED TO EMPLOYEES (line 8C + line 9C - line 10C) | $- |

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

| | | A. Total Area | B. Nursing Home Area | C. Emp. Unique Fringe Benefit Area | Non-Nursing Home Areas w/ Plant Operation and Maint. D. | E. | F. |
|---|---|---|---|---|---|---|---|
| 12. | Total square feet for areas | 51,752 | 51,752 | | | | |
| 13. | Ratio to total square feet to 4 decimals . . | 1.0000 | 1.0000 | | | | |
| 14. | TOTAL PATIENT OP/MAINT EXP. ALLOC. | $190,556 From S25, L18 | $190,556 14A X 13B | $- 14A X 13C | $- 14A X 13D | $- 14A X 13E | $- 14A X 13F |

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# SCHEDULE 25B - ALLOCATION OF HOUSEKEEPING, LAUNDRY, SECURITY AND TRANSPORTATION

## SECTION A - ALLOCATION OF HOUSEKEEPING EXPENSES

| | A. Total | B. Nursing Home Area | Non-Nursing Home Areas Receiving Housekeeping Services | | |
|---|---|---|---|---|---|
| 15. Square feet or hours of service provided | 51,752 | 51,752 | | | |
| 16. Ratio to total sq. ft./hours to 4 decimals | 1.0000 | 1.0000 | | | |
| 17. TOTAL HOUSEKEEPING EXP. ALLOC. | $131,384 | $131,384 | $- | $- | $- |
| | From S25, L18 | 17A X 16B | 17A X 16C | 17A X 16D | 17A X 16E |

## SECTION B - ALLOCATION OF LAUNDRY AND LINEN EXPENSES

| | A. Total | B. Nursing Home Area | Non-Nursing Home Areas Receiving Laundry/Linen Services | | |
|---|---|---|---|---|---|
| 18. Pounds of laundry processed | - | - | | | |
| 19. Ratio to total pounds to 4 decimals . . . . . | 1.0000 | | | | |
| 20. TOTAL LAUNDRY/LINEN EXP. ALLOC. | $92,603 | $- | $- | $- | $- |
| | From S25, L18 | 20A X 19B | 20A X 19C | 20A X 19D | 20A X 19E |

## SECTION C - ALLOCATION OF SECURITY EXPENSES

| | A. Total | B. Nursing Home Area | Non-Nursing Home Areas Receiving Security Services | | |
|---|---|---|---|---|---|
| 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

| | A. Total | B. Nursing Home Area | Non-Nursing Home Areas Receiving Transportation Services | | |
|---|---|---|---|---|---|
| 24. Alloc. Basis, Specify: 0 | - | - | | | |
| 25. Ratio to total alloc. basis to 4 decimals | 1.0000 | | | | |
| 26. TOTAL TRANS. EXPENSE ALLOC. | $7,714 | $- | $- | $- | $- |
| | From S25, L18 | 26A X 25B | 26A X 25C | 26A X 25D | 26A X 25E |

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# SCHEDULE 26 - ADMINISTRATIVE SERVICE EXPENSES

**INSTRUCTIONS:** For facilities managed by an outside, contracted management firm, the amount of management fee expense for the cost reporting period must be separately identified and reported on line 10 of this schedule. Enclose a copy of the management contract that was in effect during the cost reporting period.

| **SECTION A - SALARY AND WAGES** | **A. General Admin. Serv.** | **B. Medical Records** | **C. Central Supply** | **D.Accounting/Other Serv.** | **E. TOTAL (sum A-D)** |
|---|---|---|---|---|---|
| 1. TOTAL SALARY AND WAGE EXPENSE . . . . . | $252,307 | $36,624 | $10,637 | $57,128 | $356,696 |

**SECTION B -RELATED ORGANIZATION CENTRAL SERVICE COSTS**

| | | |
|---|---|---|
| 6. | Home office costs allocated to facility | $506,409 |
| 7. | County costs allocated to facility | - |

**SECTION C - NON-SALARY EXPENSES**

| | | |
|---|---|---|
| 8. | Purchased services - legal | |
| 9. | Licensed bed assessment | 216,240 |
| 10. | Contractual management fees | |
| 11. | Total other non-salary (from schedule 26 attachment) | 135,060 |

**SECTION D - TOTAL**

| | | |
|---|---|---|
| 12. | TOTAL ADMINISTRATIVE SERVICE EXPENSES (Sum 1, 6-11) | $1,214,405 |

**SECTION E - HOME OFFICE COST ALLOCATION REPORT**

Parent or chain organizations must submit a Home Office Cost Allocation Report or a Medicare Home Office Cost Statement (or other home office report form acceptable to Medicare). A copy of the completed report should be sent to the Regional Auditor's office.

A county facility can base the county centralized service costs allocated to the facility on the countrywide cost allocation plan. A separate Home Office Cost Allocation Report does not need to be completed.

Name of home office FAS, LLC & FCOS, LLC From (date) 1/1/2019 through (date) 12/31/2019

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# SCHEDULE 26 - ADMINISTRATIVE SERVICE EXPENSES - RELATED PARTY

**INSTRUCTIONS:** For facilities managed by an outside, contracted management firm, the amount of management fee expense for the cost reporting period must be separately identified and reported on line 10 of this schedule. Enclose a copy of the management contract that was in effect during the cost reporting period.

| **SECTION A - SALARY AND WAGES** | **A. General Admin. Serv.** | **B. Medical Records** | **C. Central Supply** | **D.Accounting/Other Serv.** | **E. TOTAL (sum A-D)** |
|---|---|---|---|---|---|
| 1. TOTAL SALARY AND WAGE EXPENSE . . . . . | | | | | $- |

**SECTION B -RELATED ORGANIZATION CENTRAL SERVICE COSTS**

| | | |
|---|---|---|
| 6. | Home office costs allocated to facility | |
| 7. | County costs allocated to facility | |

**SECTION C - NON-SALARY EXPENSES**

| | | |
|---|---|---|
| 8. | Purchased services - legal | |
| 9. | Licensed bed assessment | |
| 10. | Contractual management fees | |
| 11. | Total other non-salary (from schedule 26 attachment) | - |

**SECTION D - TOTAL**

| | | |
|---|---|---|
| 12. | TOTAL ADMINISTRATIVE SERVICE EXPENSES (Sum 1, 6-11) | $- |

**SECTION E - HOME OFFICE COST ALLOCATION REPORT**

Parent or chain organizations must submit a Home Office Cost Allocation Report or a Medicare Home Office Cost Statement (or other home office report form acceptable to Medicare). A copy of the completed report should be sent to the Regional Auditor's office.

A county facility can base the county centralized service costs allocated to the facility on the countrywide cost allocation plan. A separate Home Office Cost Allocation Report does not need to be completed.

Name of home office _____ From (date) _____ through (date) _____

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# SCHEDULE 26 ATTACHMENT - OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES

**INSTRUCTIONS:** Itemize the expenses for other non-salary administrative service expenses which are reported on schedule 26, line 11. Use account descriptions from the facility general ledger with as much detail as possible.

| | Description of Other Non-Salary Administrative Service Expenses | Expense Amount |
|---|---|---|
| 1. | Equipment Rental | $473 |
| 2. | Telephone | 43,503 |
| 3. | Forms & Printing | 2,874 |
| 4. | Training & Education | 1,428 |
| 5. | Supplies | 13,691 |
| 6. | Employee Hiring & Moving | 2,371 |
| 7. | Dues/Subscriptions | 5,326 |
| 8. | Purchased Services-Accounting | - |
| 9. | Total Other (Attached Schedule of Items) | 65,394 |
| 10. | | |
| 11. | | |
| 12. | | |
| 13. | | |
| 14. | | |
| 15. | | |
| **16.** | **TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (Should equal schedule 26, line 11) . . . . . .** | **$135,060** |

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# SCHEDULE 26 ATTACHMENT - OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES - RELATED PARTY

**INSTRUCTIONS:** Itemize the expenses for other non-salary administrative service expenses which are reported on schedule 26, line 11. Use account descriptions from the facility general ledger with as much detail as possible.

| | 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.** | **TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (Should equal schedule 26, line 11) . . . . . .** | **$-** |

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# SCHEDULE 26B - ALLOCATION OF ADMINISTRATIVE EXPENSES

**INSTRUCTIONS:** On line 17, enter the quantitative amounts for the allocation basis used by the facility. Describe the type of basis used and how it was determined.

1. Total Admin. Service Expense (S26, 12) $1,214,405

## SECTION A - DIRECT EXPENSES

| Exp. Directly Ascribable To Each Activity | A. Total | B. NH Provider | Non-Nursing Home Areas Receiving Administrative Services | | |
|---|---|---|---|---|---|
| 2. 0 | $- | $- | | | |
| 3. | - | | | | |
| 4. | - | | | | |
| 5. | - | | | | |
| 6. | - | | | | |
| 7. | - | | | | |
| 8. | - | | | | |
| 9. | - | | | | |
| 10. | - | | | | |
| 11. | - | | | | |
| 12. | - | | | | |
| 13. | - | | | | |
| 14. | - | | | | |
| 15. TOTAL DIRECT EXP. (sum 2-14) . . . . . | $- | $- | | | |
| 16. NET UNASSIGNED EXP. (line 1-line 15) | $1,214,405 | | | | |

## SECTION B - ALLOC. OF INDIRECT EXP.

| | A. Total | B. NH Provider | | | |
|---|---|---|---|---|---|
| 17. Allocation basis amounts . . . . . | - | | | | |
| 18. Ratio to total basis to 4 decimals . . . . . | 1.0000 | 1.0000 | | | |
| 19. UNASSIGNED ADMIN. EXP. ALLOC . . . . . | $1,214,405 | 1,214,405 | - | - | - |
| | net from line 16 | 19A X 18B | 19A X 18C | 19A X 18D | 19A X 18E |
| 20. TOTAL ADMINISTRATIVE EXPENSE . . . . . | $1,214,405 | $1,214,405 | $- | $- | $- |
| | (line 15A + 19A) | B15 + B19 | C15 + C19 | D15 + D19 | E15 + E19 |

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# SCHEDULE 27 - OTHER COST CENTERS

| **SECTION A - SALARY AND WAGES** | **A. Nurse Aide Training** | **B. Beauty/Barber Shop** | | | |
|---|---|---|---|---|---|
| 1. TOTAL SALARY AND WAGE EXPENSE | | | | | |
| 2. NUMBER OF HOURS WORKED | | | | | |

| **SECTION B - NON-SALARY EXPENSES** | **A. Nurse Aide Training** | **B. Beauty/Barber Shop** | - | - | - |
|---|---|---|---|---|---|
| 3. Advertising & P.R. | $- | $- | $- | $- | $- |
| 4. Meals, Entertainment, Meetings & Tra | - | - | - | - | - |
| 5. Outside Services | - | - | - | - | - |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | | | | | |
| 12. | | | | | |
| 13. | | | | | |
| 14. | | | | | |
| 15. **TOTAL NON-SALARY EXPENSES** | $- | $- | $- | $- | $- |

| **SECTION C - TOTAL** | **A. Nurse Aide Training** | **B. Beauty/Barber Shop** | - | - | - |
|---|---|---|---|---|---|
| **16. TOTAL EXPENSES (Sum 1, 3-14)** . . . . . | | | | | |

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# SCHEDULE 28 - EMPLOYEE FRINGE BENEFIT EXPENSES

**INSTRUCTIONS:** Under the column labeled "Self-Funded", indicate yes or no. **If yes, attach documentation to support the amount claimed for each self-funded benefit by completing and saving the "Sch 28 S-F FB" worksheet.**

## SECTION A - FRINGE BENEFITS PAID ON BEHALF OF EMPLOYEES

| | Fringe Benefits Paid on Behalf of Employees | Self-Funded? | Expense |
|---|---|---|---|
| 1. | Employer's share of F.I.C.A. | | $263,608 |
| 2. | State unemployment compensation | | 17,465 |
| 3. | Federal unemployemnt compensation | | 5,366 |
| 4. | Worker's compensation insurance | [ ] Yes [x] No | 31,911 |
| 5. | Health, Dental & Vision Insurance | [x] Yes [ ] No | 710,532 |
| 6. | Life and disability insurance | [ ] Yes [ ] No | |
| 7. | Wage continuation insurance | [ ] Yes [ ] No | |
| 8. | Pension and deferred comp. plans (section C) | [ ] Yes [ ] No | |
| 9. | Employee physicals and vaccines (if pre-employment, report costs on Sch 26-Attachment) | | |
| 10. | Uniforms | | 208 |
| 11. | Other Employee Benefits | | 9,331 |
| 12. | Bonuses | | 20,000 |
| 13. | | | |
| 14. | | | |
| 15. | TOTAL PAID ON BEHALF OF EMPLOYEES (sum 1-14) | | $1,058,421 |
| 16. | Expense for special salary or wage payments to employees not lincluded elsewhere (section D) | | - |
| **17.** | **TOTAL FRINGE BENEFIT EXPENSE(sum 15+16)** | | **$1,058,421** |

## SECTION D - SPECIAL SALARY AND WAGE PAYMENTS TO EMPLOYEES

**INSTRUCTIONS:** Check the types of special salary and wage payments to employees which are included in section A, line 16.

[ ] Christmas bonus [ ] Longevity bonus [ ] Productivity bonus [x] Other, Specify: Performance

[ ] Bonuses to owners and immediate family relations, Specify:

# Self-Funded Fringe Benefit Worksheet

*Complete this form if you indicated any self-funded fringe benefits on Schedule 28. Press Ctrl-Shift-K to save this worksheet as a separate supporting document.*

**Facility Name** The Pavilion at Glacier Valley

**Cost Report Period** 1/1/2019 12/31/2019

| | Type of Self-Funded Expenses | Worker's Compensation Insurance | Health, Dental and Vision Insurance | Life and Disability Insurance | Wage Continuation Insurance | Pension and Deferred Compensation Plans |
|---|---|---|---|---|---|---|
| | *Checked as self-funded on Sch 28?* | | x | | | |
| 1 | Actual Claims Paid | | | | | |
| 2 | Premium costs for re-insurance (stop loss) policies purchased from an unrelated party | | | | | |
| 3 | Costs paid to administer the self insurance plan not reported elsewhere in the cost report | | | | | |
| 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 | | | | | |
| 6 | Employee Contributions | | | | | |
| 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 | | | | | |
| 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) | $- | $- | $- | $- | $- |

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# SCHEDULE 29 - HEATING FUEL AND UTILITY EXPENSES

**INSTRUCTIONS:** Report the accrued expense incurred during the cost reporting period for each type of heating fuel and utility service.

Accounts payable: The expense should be adjusted to excluded beginning accounts payable and to include ending accounts payable for the reporting period. Make sure to include exactly 12 months of expense for a full-year cost report and exactly six months of expense for a six-month cost report.

Inventories: The expense for heating and fuels such as heating oil, L.P. gas and coal should be adjusted for changes in inventories between the beginning and ending dates of the cost reporting period.

Cost allocation: In section B, allocate the fuel and utility expense between the Medicaid nursing home area and other major revenue-generating areas or non-nursing home areas. Describe the allocation technique if an allocation basis other than square footage is used. The allocation basis used is similar to the maintenance allocation on schedule 25A.

## SECTION A - ACCRUED EXPENSE BY TYPE

| | Expense by Type | Accrued Expense | | Expense by Type | Accrued Expense |
|---|---|---|---|---|---|
| 1. | Fuel oil | - | 6. | Water and sewer utility charges | 29,449 |
| 2. | Natural gas | 17,441 | 7. | Purchased steam | - |
| 3. | L.P. gas | - | 8. | | |
| 4. | Coal | - | 9. | | |
| 5. | Electricity | 137,275 | **10.** | **TOTAL FUEL AND UTILITY EXPENSE . . .** | **$184,165** |

## SECTION B - ALLOCATION OF FUEL AND UTILITY EXPENSE

| | | | | | Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv. | | |
|---|---|---|---|---|---|---|---|
| | | A. Total | B. NH Area | C. Emp. Unique Fringe Ben. Area | | | |
| 11. | Total square feet for areas | 51,752 | 51,752 | | | | |
| 12. | Ratio to total square feet to 4 decimals | 1.0000 | 1.0000 | | | | |
| **13.** | **TOTAL ALLOC. FUEL/UTIL. EXPENSE** | **184,165** | **$184,165** | **$-** | **$-** | **$-** | **$-** |
| | | From line 10 | 13A X 12B | 13A X 12C | 13A X 12D | 13A X 12E | 13A X 12F |

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## SCHEDULE 30 - INTEREST EXPENSES ON OPERATING WORKING CAPITAL LOANS

| | Name of Lender | Is Lender a Related Party? | Interest Expense |
|---|---|---|---|
| 1a. | CAPSOURCE & ALLY (INCLUDED IN HOME OFFICE ALLOCATIONS) | b. [ ] Yes [X] No | $- |
| 2a. | | b. [ ] Yes [ ] No | |
| 3a. | | b. [ ] Yes [ ] No | |
| 4a. | | b. [ ] Yes [ ] No | |
| 5a. | | b. [ ] Yes [ ] No | |
| 6. | **TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS (sum 1-5)** | | **$-** |

## SCHEDULE 31 - INSURANCE EXPENSES

| | Type of Insurance Coverage | Self-Funded? | Insurance Expense |
|---|---|---|---|
| 1. | Property insurance on building and contents | [ ] Yes [X] No | $17,661 |
| 2. | Automobile insurance | [ ] Yes [X] No | 3,764 |
| 3. | Liability insurance | [X] Yes [ ] No | 13,588 |
| 4. | Business interruption insurance | [ ] Yes [ ] No | |
| 5. | Life insurance on owners and employes with facility as the beneficiary | [ ] Yes [ ] No | |
| 6. | Mortgage insurance | [ ] Yes [ ] No | |
| 7. | Other Property | [ ] Yes [ ] No | |
| 8. | Other General — Lockton Insurance on Surety Bonds | [ ] Yes [X] No | 467 |
| **9.** | **TOTAL INSURANCE EXPENSE** | | **$35,480** |

## SCHEDULE 32 - AMORTIZATION OF DEFERRED EXPENSES

| | A. Deferred Exp. Or Asset Being Amortized (give detailed description) | B. Original Cost | C. Year Cost Incurred | D. Number of Years Amortized | E. Unamortized Begin. Balance | F. Unamortized End. Balance | G. Amortization Expense |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| **5.** | **TOTAL AMORTIZATION EXPENSE** | | | | | | **$-** |

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## SCHEDULE 30 - INTEREST EXPENSES ON OPERATING WORKING CAPITAL LOANS - RELATED PARTY

| | Name of Lender | Is Lender a Related Party? | Interest Expense |
|---|---|---|---|
| 1a. | | ☐ Yes ☐ No | |
| 2a. | | ☐ Yes ☐ No | |
| 3a. | | ☐ Yes ☐ No | |
| 4a. | | ☐ Yes ☐ No | |
| 5a. | | ☐ Yes ☐ No | |
| **6.** | **TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS (sum 1-5).** | | **$-** |

## SCHEDULE 31 - INSURANCE EXPENSES - RELATED PARTY

| | Type of Insurance Coverage | Self-Funded? | Insurance Expense |
|---|---|---|---|
| 1. | Property insurance on building and contents | ☐ Yes ☐ No | |
| 2. | Automobile insurance | ☐ Yes ☐ No | |
| 3. | Liability insurance | ☐ Yes ☐ No | |
| 4. | Business interruption insurance | ☐ Yes ☐ No | |
| 5. | Life insurance on owners and employes with facility as the beneficiary | ☐ Yes ☐ No | |
| 6. | Mortgage insurance | ☐ Yes ☐ No | |
| 7. | | ☐ Yes ☐ No | |
| 8. | | ☐ Yes ☐ No | |
| **9.** | **TOTAL INSURANCE EXPENSE** | | **$-** |

## SCHEDULE 32 - AMORTIZATION OF DEFERRED EXPENSES - RELATED PARTY

| | A. Deferred Exp. Or Asset Being Amortized (give detailed description) | B. Original Cost | C. Year Cost Incurred | D. Number of Years Amortized | E. Unamortized Begin. Balance | F. Unamortized End. Balance | G. Amortization Expense |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| **5.** | **TOTAL AMORTIZATION EXPENSE** | | | | | | **$-** |

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## SCHEDULE 33 - INTEREST EXPENSES ON 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 D. Begin date 1/1/2019 Begin Bal. | E. 6Mo.date #NAME? 6 Mo. Bal. | F. End date 12/31/2019 End Bal. | G. Interest Rate | H. Interest Expense |
|---|---|---|---|---|---|---|---|---|
| 1a. Name | | | | | | | | |
| 1b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 1c. Purpose | | | | | | | | |
| 2a. Name | | | | | | | | |
| 2b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 2c. Purpose | | | | | | | | |
| 3a. Name | | | | | | | | |
| 3b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 3c. Purpose | | | | | | | | |
| 4a. Name | | | | | | | | |
| 4b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 4c. Purpose | | | | | | | | |
| 5a. Name | | | | | | | | |
| 5b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 5c. Purpose | | | | | | | | |
| 6a. Name | | | | | | | | |
| 6b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 6c. Purpose | | | | | | | | |
| 7a. Name | | | | | | | | |
| 7b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 7c. Purpose | | | | | | | | |
| **15 TOTAL LOAN PRINCIPAL** . . . . . | | | | $- | $- | $- | **TOTAL EXP.** . . . . . | $- |

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## SCHEDULE 33, PAGE 2 - INTEREST EXPENSES ON 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 D. Begin date 1/1/2019 Begin Bal. | E. 6Mo.date #NAME? 6 Mo. Bal. | F. End date 12/31/2019 End Bal. | G. Interest Rate | H. Interest Expense |
|---|---|---|---|---|---|---|---|---|
| 8a. Name | | | | | | | | |
| 8b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 8c. Purpose | | | | | | | | |
| 9a. Name | | | | | | | | |
| 9b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 9c. Purpose | | | | | | | | |
| 10a. Name | | | | | | | | |
| 10b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 10c. Purpose | | | | | | | | |
| 11a. Name | | | | | | | | |
| 11b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 11c. Purpose | | | | | | | | |
| 12a. Name | | | | | | | | |
| 12b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 12c. Purpose | | | | | | | | |
| 13a. Name | | | | | | | | |
| 13b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 13c. Purpose | | | | | | | | |
| 14a. Name | | | | | | | | |
| 14b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 14c. Purpose | | | | | | | | |
| 16 TOTALS FOR SCHEDULE 33, PAGE 2 ONLY | | | | $- | $- | $- | | $- |

**SEE SCHEDULE 33 FOR TOTAL LOAN PRINCIPAL OF SCHEDULE 33 AND SCHEDULE 33, PAGE 2**

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## SCHEDULE 33 - INTEREST EXPENSES ON PLANT ASSET LOANS - RELATED PARTY

| 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 D. Begin date 1/1/2019 Begin Bal. | E. 6Mo.date #NAME? 6 Mo. Bal. | F. End date 12/31/2019 End Bal. | G. Interest Rate | H. Interest Expense |
|---|---|---|---|---|---|---|---|---|
| 1a. Name | | | | | | | | |
| 1b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 1c. Purpose | | | | | | | | |
| 2a. Name | | | | | | | | |
| 2b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 2c. Purpose | | | | | | | | |
| 3a. Name | | | | | | | | |
| 3b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 3c. Purpose | | | | | | | | |
| 4a. Name | | | | | | | | |
| 4b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 4c. Purpose | | | | | | | | |
| 5a. Name | | | | | | | | |
| 5b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 5c. Purpose | | | | | | | | |
| 6a. Name | | | | | | | | |
| 6b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 6c. Purpose | | | | | | | | |
| 7a. Name | | | | | | | | |
| 7b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 7c. Purpose | | | | | | | | |
| **15 TOTAL RELATED PARTY LOAN PRINCIPAL** | | | | $- | $- | $- | **TOTAL EXP.** | $- |

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## SCHEDULE 33, PAGE 2 - INTEREST EXPENSES ON PLANT ASSET LOANS - RELATED PARTY

| 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 D. Begin date 1/1/2019 Begin Bal. | E. 6Mo.date #NAME? 6 Mo. Bal. | F. End date 12/31/2019 End Bal. | G. Interest Rate | H. Interest Expense |
|---|---|---|---|---|---|---|---|---|
| 8a. Name | | | | | | | | |
| 8b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 8c. Purpose | | | | | | | | |
| 9a. Name | | | | | | | | |
| 9b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 9c. Purpose | | | | | | | | |
| 10a. Name | | | | | | | | |
| 10b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 10c. Purpose | | | | | | | | |
| 11a. Name | | | | | | | | |
| 11b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 11c. Purpose | | | | | | | | |
| 12a. Name | | | | | | | | |
| 12b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 12c. Purpose | | | | | | | | |
| 13a. Name | | | | | | | | |
| 13b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 13c. Purpose | | | | | | | | |
| 14a. Name | | | | | | | | |
| 14b. Related party? ☐ Yes ☐ No | | | | | | | | |
| 14c. Purpose | | | | | | | | |
| 16 TOTALS FOR SCHEDULE 33, PAGE 2 ONLY | | | | $- | $- | $- | | $- |

**SEE SCHEDULE 33- RELATED PARTY FOR TOTAL LOAN PRINCIPAL OF SCHEDULE 33 - RELATED PARTY AND SCHEDULE 33 - RELATED PARTY, PAGE 2**

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# SCHEDULE 34 - DEPRECIATION EXPENSES

**SECTION A - CAPITALIZED HISTORICAL COST**

| | Begin Date 1/1/2019 B. Beginning Balance | C. Additions During Report Period | D. Disposals During Report Period | End Date 12/31/2019 E. Ending Balance |
|---|---|---|---|---|
| 1. Land | - | - | ( - ) | $- |
| 2. Land Improvements | - | - | ( - ) | - |
| 3. Buildings | - | - | ( - ) | - |
| 4. Leasehold Improvements | 188,406 | 9,881 | ( - ) | 198,287 |
| 5. Fixed equipment | 17,980 | 1,298 | ( 1,298 ) | 17,980 |
| 6. Moveable equipment | 340,570 | 8,214 | ( 2,736 ) | 346,048 |
| 7. Transportation vehicles | - | - | ( - ) | - |
| 8. Computer Software | - | - | ( - ) | - |
| 9. Computer Hardware | 54,478 | 3,637 | ( - ) | 58,115 |
| 10. TOTAL CAPITALIZED COST . . | $601,434 | $23,030 | ( $4,034 ) | $620,430 |

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

| | A. Depreciation Method, Lives Used | Begin Date 1/1/2019 B. Beginning Balance | C. Depreciation Exp. During Report Period | D. Removal of Accum. Deprec. On Disposals. | End Date 12/31/2019 E. Ending Balance |
|---|---|---|---|---|---|
| 11. Land Improvements | Straight Line | $- | | ( ) | $- |
| 12. Buildings | Straight Line | - | | ( ) | - |
| 13. Leasehold Improvements | Straight Line | 58,709 | 12,546 | ( ) | 71,255 |
| 14. Fixed equipment | Straight Line | 2,660 | 1,172 | ( ) | 3,832 |
| 15. Moveable equipment | Straight Line | 185,427 | 24,073 | ( ) | 209,500 |
| 16. Transportation vehicles | Straight Line | - | - | ( ) | - |
| 17. Computer Software | Straight Line | - | - | ( ) | - |
| 18. Computer Hardware | Straight Line | 51,544 | 2,002 | ( ) | 53,546 |
| 19. TOTAL ACCUMULATED DEPRECIATION | | $298,340 | | ( $- ) | $338,133 |
| **20. TOTAL DEPRECIATION EXPENSE** | | | **$39,793** | | |

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

Include copies of invoices to support the cost of any Bariatric Equipment (see sec. 2.750 of Methods of Implementation for definition) purchases reported on Line 21.

Include a copy of your plant ledger that supports the amounts reported on this Schedule 34 - See Schedule 3 Line 13 B

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# SCHEDULE 34 - DEPRECIATION EXPENSES - RELATED PARTY

**SECTION A - CAPITALIZED HISTORICAL COST**

| | Begin Date / B. Beginning Balance | C. Additions During Report Period | D. Disposals During Report Period (as negaive value) | End Date / E. Ending Balance |
|---|---|---|---|---|
| | 1/1/2019 | | | 12/31/2019 |
| 1. Land | $- | | ( ) | $- |
| 2. Land Improvements | - | | ( ) | - |
| 3. Buildings | - | | ( ) | - |
| 4. Leasehold Improvements | - | | ( ) | - |
| 5. Fixed equipment | - | | ( ) | - |
| 6. Moveable equipment | - | | ( ) | - |
| 7. Transportation vehicles | - | | ( ) | - |
| 8. 0 | - | | ( ) | - |
| 9. 0 | - | | ( ) | - |
| 10. TOTAL CAPITALIZED COST . . | $- | $- | ( $- ) | $- |

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

| | A. Depreciation Method, Lives Used | Begin Date / B. Beginning Balance | C. Depreciation Exp. During Report Period | D. Removal of Accum. Deprec. On Disposals. | End Date / E. Ending Balance |
|---|---|---|---|---|---|
| | | 1/1/2019 | | | 12/31/2019 |
| 11. Land Improvements | | $- | | ( ) | $- |
| 12. Buildings | | - | | ( ) | - |
| 13. Leasehold Improvements | | - | | ( ) | - |
| 14. Fixed equipment | | - | | ( ) | - |
| 15. Moveable equipment | | - | | ( ) | - |
| 16. Transportation vehicles | | - | | ( ) | - |
| 17. 0 | | - | | ( ) | - |
| 18. 0 | | - | | ( ) | - |
| 19. TOTAL ACCUMULATED DEPRECIATION | | $- | | ( $- ) | $- |
| **20. TOTAL DEPRECIATION EXPENSE** | | | **$-** | | |

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

Include copies of invoices to support the cost of any Bariatric Equipment (see sec. 2.750 of Methods of Implementation for definition) purchases reported on Line 21.

Include a copy of your plant ledger that supports the amounts reported on this Schedule 34 - See Schedule 3 Line 13 B

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# SCHEDULE 35 - LEASE EXPENSES ON OPERATING LEASES AND NON-CAPITALIZED LEASES

**INSTRUCTIONS: F** For any lessor that is a related party to the provider, report the lessor's ownership cost of the property and complete and attach copies of schedules 31, 32, 33, 34, 37 and 39. Label the schedule copies, "Related Party Leased Property".

For any lease contract expense which totals above $5,000, submit a copy of the lease.

Identify any of the leased property listed below which was formerly owned by the leasing provider.

## 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. Month, Year acquired use | F. Describe Property | G. Lease Exp. |
|---|---|---|---|---|---|---|---|
| 1. | LTC Properties, Inc. | ☐ Yes ☒ No | ☐ Yes ☒ No | $- | Feb-15 | The Pavilion at Glacier Valley | $1,676,748 |
| 2. | | ☐ Yes ☐ No | ☐ Yes ☐ No | | | | |
| 3. | | ☐ Yes ☐ No | ☐ Yes ☐ 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. Month, Year acquired use | F. Describe Property | G. Lease Exp. |
|---|---|---|---|---|---|---|---|
| 4. | Joerns Healthcare Rentals | ☐ Yes ☒ No | ☐ Yes ☒ No | $- | Jan-19 | Mattresses | $9,801 |
| 5. | Joerns Healthcare Rentals | ☐ Yes ☒ No | ☐ Yes ☒ No | - | Jan-19 | Beds | 57,846 |
| 6. | Canon Financial Services | ☐ Yes ☒ No | ☐ Yes ☒ No | - | Jan-19 | Copiers | 2,740 |
| 7. | Joerns Healthcare Rentals | ☐ Yes ☒ No | ☐ Yes ☒ No | - | Jan-19 | Wheelchairs | 6,192 |
| 8. | | ☐ Yes ☐ No | ☐ Yes ☐ No | | | | |
| 9. | | ☐ Yes ☐ No | ☐ Yes ☐ No | | | | |
| 10. | | ☐ Yes ☐ No | ☐ Yes ☐ No | | | | |
| 11. | | ☐ Yes ☐ No | ☐ Yes ☐ No | | | | |
| 12. | | ☐ Yes ☐ No | ☐ Yes ☐ No | | | | |
| 13. | | ☐ Yes ☐ No | ☐ Yes ☐ No | | | | |

## SECTION C - TOTAL

**14. TOTAL LEASE EXPENSE ON OPERATING LEASES AND NON-CAPITALIZED LEASES (sum 1-13)** **$1,753,327**

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# SCHEDULE 36A - LEASE EXPENSES ON CAPITALIZED LEASES

**INSTRUCTIONS:** For any lessor that is a related party to the provider, report the lessor's ownership cost of the property and complete and attach copies of schedules 31, 32, 33, 33 page 2 (if applicable), 34, 37 and 39. Label the schedule copies, "Related Party Leased Property".

For any lease contract expense which totals above $5,000, submit a copy of the lease.

Identify any of the leased property listed below which was formerly owned by the leasing provider on Schedule 36B.

**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 (sum 1a-1c) _____

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 (sum 2a-2c) _____

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 (sum 1a-1c) _____

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 (sum 1a-1c) _____

5. **TOTAL CAPITALIZED LEASE EXPENSE FOR REPORTING PERIOD - Transfer to Schedule 12 (sum 1d+2d+3d+4d) . . . . . $-**

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# SCHEDULE 36B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

**INSTRUCTIONS:**

Identify any of the leased property listed below which was formerly owned by the leasing provider.

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

A1. Name of lessor _____ A2. Actual payments required by lease in report period . . . . . _____

A3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☐ No A4. If yes, (schedule) _____ (line) _____ (amount) _____

B1. Name of lessor _____ B2. Actual payments required by lease in report period . . . . . _____

B3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☐ No B4. If yes, (schedule) _____ (line) _____ (amount) _____

C1. Name of lessor _____ C2. Actual payments required by lease in report period . . . . . _____

C3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☐ No C4. If yes, (schedule) _____ (line) _____ (amount) _____

D1. Name of lessor _____ D2. Actual payments required by lease in report period . . . . . _____

D3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☐ No D4. If yes, (schedule) _____ (line) _____ (amount) _____

**E. TOTAL CAPITALIZED LEASE PAYMENTS RELATED TO CAPITALIZED LEASES (sum A2+B2+C2+D2) . . . . . $-**

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# SCHEDULE 37 - PROPERTY TAX EXPENSES

**INSTRUCTIONS:** Only tax exempt facilities should report the expense for municipal services which are financed through municipality property taxes. Describe the services.

**SECTION A - FOR ALL PROVIDERS** — **Expense**

1. 2019 real estate tax (due in 2020) relating to the nursing home operation (attach copy of bill or, if not yet received, send separately upon receipt.) — $200,515
2. 2019 personal property tax (due in 2020) relating to the nursing home operation (attach copy bill or, if not yet received, send separately upon receipt.) — 2,651

3a. Have the amounts reported on lines 1 and 2 been paid in full? [x] 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. 2017 or 2018? [ ] Yes, explain below [x] No

Tax year _____ Amount still outstanding _____ Tax year _____ Amount still outstanding _____

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

4. Amount of municipal service fee expense incurred by the nursing home appropriately accrued to calendar year 2019.
5. Identify where municipal service fee expenses are reported in the cost report if not above on this schedule. Attach a copy of the bill.

Cost center name _____ Schedule number _____ Line number _____ Amount reported _____

6. The facility began to pay municipal service fees (check one) [ ] Prior to January 2019 [ ] On or after January 2019 Date began paying fees _____
7. Describe the services provided by the municipality for the above fees. _____
8. Payment of the above fees was (check one) [ ] Voluntary [ ] Required by the tax authority

**9. TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE** . . . . . **$203,166**

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# SCHEDULE 37 - PROPERTY TAX EXPENSES - RELATED PARTY

**INSTRUCTIONS:** Only tax exempt facilities should report the expense for municipal services which are financed through municipality property taxes. Describe the services.

**SECTION A - FOR ALL PROVIDERS** **Expense**

1. 2019 real estate tax (due in 2020) relating to the nursing home operation (attach copy of bill or, if not yet received, send separately upon receipt.)
2. 2019 personal property tax (due in 2020) relating to the nursing home operation (attach copy bill or, if not yet received, send separately upon receipt.)

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. 2017 or 2018? ☐ Yes, explain below ☐ No

Tax year _____ Amount still outstanding _____ Tax year _____ Amount still outstanding _____

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

4. Amount of municipal service fee expense incurred by the nursing home appropriately accrued to calendar year 2019.
5. Identify where municipal service fee expenses are reported in the cost report if not above on this schedule, section A, line 7.

Cost center name _____ Schedule number _____ Line number _____ Amount reported _____

6. The facility began to pay municipal service fees (check one) ☐ Prior to January 2019 ☐ On or after January 2019 Date began paying fees _____
7. Describe the services provided by the municipality for the above fees. _____
8. Payment of the above fees was (check one) ☐ Voluntary ☐ Required by the tax authority

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

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## SCHEDULE 38 - NO LONGER USED

## SCHEDULE 39 - OTHER NON-SALARY EXPENSES

**INSTRUCTIONS:** Report and describe the nature and source of any non-salary expenses not included elsewhere in this cost report. Other salary expenses should be reported on schedule 27.

| | Nature and Source of Expense | Expense |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| **4.** | **TOTAL OTHER NON-SALARY EXPENSES (sum 1 - 3). . . . . .** | **$-** |

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# SCHEDULE 40 - ALLOCATION OF PROPERTY EXPENSES

**INSTRUCTIONS:** Assign expenses directly ascribable to or identifiable with each service's building area. Use column C for unique fringe benefit building areas.

| | | | Areas for Non-NH Serv. Or Other Major Revenue-Generating Activities | | |
|---|---|---|---|---|---|
| | | | C. | D. | E. |
| **SECTION A - DIRECT PROPERTY EXP.** | **A. Total From Sched.** | **B. NH Service Area** | | | |
| 1. Property insurance (s31) | $17,661 | | | | |
| 2. Mortgage insurance (s31) | - | | | | |
| 3. Amortization debt premium discount (s32) | - | | | | |
| 4. Plant asset interest expense (s33) | - | | | | |
| 5. Depreciation land improvements (s34) | - | | | | |
| 6. Depreciation buildings (s34) | - | | | | |
| 7. Depreciation leasehold improve. (s34) | 12,546 | | | | |
| 8. Depreciation fixed equipment (s34) | 1,172 | | | | |
| 9. Depreciation moveable equip. (s34) | 24,073 | | | | |
| 10. Depreciation transportation veh. (s34) | - | | | | |
| 11. Depreciation other (s34) | 2,002 | | | | |
| 12. Expense on operating leases (s35) | 1,753,327 | | | | |
| 13. Expense on capitalized leases (s36) | - | | | | |
| 14. Property taxes or fees (s37) | 203,166 | | | | |
| 15. TOTAL EXPENSE (sum 1-14) | $2,013,947 | $- | | | |
| 16. Less total directly assigned property exp. | $- | (sum 15B, 15C 15D, 15E) | | | |
| **17. NET UNASSIGNED/INDIRECT PROP. . . . .** | **$2,013,947** | (15A less 16A) | | | |
| **SECTION B - NON-SALARY EXPENSES** | **A. Total From Sched.** | **B. NH Area** | | | |
| 18. Square feet of service's building area | 51,752 | 51,752 | | | |
| 19. Ratio to total square feet to 4 decimals | 1.0000 | 1.0000 | | | |
| 20. Indirect property expense allocation | $2,013,947 (from 17A) | 2,013,947 20A X 19B | - 20A X 19C | - 20A X 19D | - 20A X 19E |
| **SECTION C - TOTAL** | **A. Total From Sched.** | **B. NH Area** | | | |
| **21. TOTAL PROP. EXP. FOR EACH AREA** | **$2,013,947** 17A + 20 A | **$2,013,947** 15B + 20B | **$-** 15C + 20C | **$-** 15D + 20D | **$-** 15E + 20E |

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# SCHEDULE 41 - ACCOUNTING AND REPORTING POLICIES

## 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. [X] Accrual [ ] Cash
2. Capitalization of plant assets - briefly describe the facility's policy or practice for the capitalization of plant assets purchases.
   0
3. Volunteer and unpaid employees - briefly explain if and how volunteer and other unpaid employee hours are reported in this cost report
   0
4. Conformity - describe any accounting practices/policies in reporting revenues and expenses which are known to NOT conform to generally accepted accounting principles.
   0

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

**INSTRUCTIONS:** Reporting on the basis of earned time-off is not permitted. Vacation, Holiday and Sick Time (VS) salaries and hours must be reported on the basis of the time-off actually taken by employees during the cost reporting period. For column B, describe the estimation techniques used and add sheets if needed.

| Type of Paid Time-Off | A. Based on Actual or Earned Time-Off? | | B. Are Reported Amounts an Estimate? | |
|---|---|---|---|---|
| 1. Vacation | [X] Actual | [ ] Earned | [ ] Yes | [X] No |
| 2. Holidays | [X] Actual | [ ] Earned | [ ] Yes | [X] No |
| 3. Sick time | [X] Actual | [ ] Earned | [ ] Yes | [X] No |
| 4. Break, meal time | [X] Actual | [ ] Earned | [ ] Yes | [X] No |
| 5. Holiday premium | [X] Actual | [ ] Earned | [ ] Yes | [X] No |
| 6. In-service training | [X] Actual | [ ] Earned | [ ] Yes | [X] No |
| 7. _____ | [ ] Actual | [ ] Earned | [ ] Yes | [ ] No |

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# SCHEDULE 42 - IDENTIFICATION OF EXPENSES FROM TRANSACTIONS WITH RELATED PARTIES AND ORGANIZATIONS

## SECTION A - RELATED PARTY LEASES

| | A. Description of Expense Item | Location and Amount of Expense Included in This Cost Report: B. Cost Ctr. | C. Schedule | D. Column | E. Line | F. Expense | G. Expense Incurred by Related Party | H. Difference (G - F) |
|---|---|---|---|---|---|---|---|---|
| 1. | Total related party lease expense | | | | | ( ) | XXXXXXXXX | XXXXXXXXX |
| 2. | Insurance expense | | | | | XXXXXXXXX | | XXXXXXXXX |
| 3. | Amortization deferred expense | | | | | XXXXXXXXX | | XXXXXXXXX |
| 4. | Interest expense | | | | | XXXXXXXXX | | XXXXXXXXX |
| 5. | Depreciation expense | | | | | XXXXXXXXX | | XXXXXXXXX |
| 6. | Property tax expense | | | | | XXXXXXXXX | | XXXXXXXXX |
| 7. | | | | | | XXXXXXXXX | | XXXXXXXXX |
| 8. | | | | | | XXXXXXXXX | | XXXXXXXXX |
| 9. | SUBTOTAL FOR RELATED PARTY LEASES | | | | | ( $- ) | $- | $- |

## SECTION B - OTHER RELATED PARTY TRANSACTIONS

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 10. | Admin/Clinical Support | Administrative | 26 | E | 6 | ( $506,409 ) | $506,409 | $- |
| 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 names and cities of location of the related parties and organizations with whom the nursing home provider has transacted business during the cost report period.

FAS, LLC and FCOS, LLC, c/o FAS, LLC 920 Ridgebrook Road, Sparks, MD 21152

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# SCHEDULE 43 - IDENTIFICATION OF EXPENSES NOT RELATED TO PATIENT CARE

**INSTRUCTIONS:** To the extent possible, identify significant expenses included in this cost report which were not related to patient care. See Section 600 of the Cost Report Instructions for more details on such expenses. Attach additional sheets if necessary.

| | | | Location of Expense in Cost Report | | |
|---|---|---|---|---|---|
| **A. Description of Expense Item** | **Amount** | **Cost Ctr.** | **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-employes | | | | | |
| 12. Special legal and professional fees (complete schedule 43A) | | | | | |
| 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 Abondoned Planning Expenses | | | | | |
| 21 Other - describe: _____ | | | | | |
| 22. Other - describe: _____ | | | | | |

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# SCHEDULE 43A - LEGAL FEES

**INSTRUCTIONS:** Identify the expenses for all legal fees included in this cost report. These expenses should have been reported on schedule 26, line 8. For the fees reported on line 2, identify any allowable amount that was specifically awarded by the administrative or judicial courts as a result of a successful appeal or prosecution.

| | Description | Legal fees |
|---|---|---|
| 1. | Prosecution or defense related to Medicare or Medicaid reimbursement | |
| 2. | Prosecution or defense pertaining to compliance with licensure or certification requirements (see instructions above) | |
| 3. | Defense of an owner or employee in a personal or criminal legal matter | |
| 4. | Legal preparation resulting in the filing of an appeal under Chapters 50 or 227, Wisconsin Statutes, or a judicial suit | |
| 5. | Collection of delinquent accounts | |
| 6. | Corporate restructuring or reorganization | |
| 7. | Potential purchase or sale of nursing home(s) | |
| 8. | Purchase or sale of nursing home(s) | |
| 9. | Negotiations with suppliers | |
| 10. | Income taxes, payroll taxes, benefit plans | |
| 11. | Union related activities | |
| 12. | Guardianship for Medicaid residents | |
| 13. | Other not related to patient care | |
| 14. | Legal Fees - Incorporation & Limited Liability Fees | - |
| 15. | | |
| **16.** | **TOTAL LEGAL FEES (should equal schedule 26, line 8).** | |

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# SCHEDULE 45 - DISTRIBUTION OF COMPENSATION EXPENSES TO KEY PERSONNEL

***Submit as a separate supporting document.SCHEDULE 45 - DISTRIBUTION OF COMPENSATION EXPENSES TO KEY PERSONNEL***

***Submit as a separate supporting document***

**INSTRUCTIONS:** Separately itemize and identify the amount of compensation expense and hours reported in each cost center of this cost report. Report the compensation paid to all owners and other related parties and immediate family relationships, all workers who are members of a religious order or society that owns the nursing home, and arm's length employees who are supervisors or managers with decision making authority.

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## SCHEDULE 46 - IDENTIFICATION OF EXPENSES FOR EMPLOYEE UNIQUE FRINGE BENEFITS

**INSTRUCTIONS:** Unique fringe benefits are those fringe benefit items provided to only a few select employees and the expenses for such benefits may be reported in one or more cost centers of this report. Identify the unique fringe benefits provided to any individual employee by reporting the expenses related to the benefit and where the expenses are included in this cost report.

| | A. Name of Employee | B. Title | C. Describe Unique Fringe Benefit Item | D. Cost Ctr. Salary Exp. | E. Cost Ctr. Benefit Exp. | F. Schedule | G. Column | H. Line | I. Benefit Expense Amount |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Capitan,Sherlandino M | DON | Bonus | 100 | 100 | 28 | 1 | 12 | 10,000 |
| 2. | Gordon, Dawn M | ADMIN | Bonus | 530 | 530 | 28 | 1 | 12 | 10,000 |
| 3. | | | | | | | | | |
| 4. | | | | | | | | | |
| 5. | | | | | | | | | |
| 6. | | | | | | | | | |
| 7. | | | | | | | | | |
| 8. | | | | | | | | | |
| 9. | | | | | | | | | |
| 10. | | | | | | | | | |
| 11. | | | | | | | | | |
| 12. | | | | | | | | | |
| 13. | | | | | | | | | |
| 14. | | | | | | | | | |
| 15. | | | | | | | | | |
| 16. | | | | | | | | | |

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## SCHEDULE 49 - PERCENTAGE OF OWNERSHIP

**INSTRUCTIONS:** List all individuals or entities that own 20% or more of the nursing home operation.

| | Name of Individual or Entity | Percentage of Ownership |
|---|---|---|
| 1. | THI OF WISCONSIN, LLC | 100% |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

## SCHEDULE 50 - INTEREST IN OTHER MEDICAID PROVIDERS

**INSTRUCTIONS:** If the nursing home organization or any of its owners, administrators, officers, or any members of their immediate families are a separate provider or had an interest in any other provider in the Wisconsin Medicaid program, list the provider and explain the nature of the interest. Report interests that existed during the cost report period and/or existed up to the date of cost report submission to the Department. Include any other Wisconsin nursing home providers. Attach additional sheets if necessary.

| | Name and City of Medicaid Provider | Type of Medical Services Provided | Nature and Extent of Interest in Provider |
|---|---|---|---|
| 1. | None in Wisconsin | 0 | 0 |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |



## SCHEDULE 51 - NO LONGER USED

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# SCHEDULE 52 - MISCELLANEOUS MEDICAID NON-RATE REVENUES

**INSTRUCTIONS:** Wisconsin Medicaid provides for separate reimbursement for certain items not included in the daily rate or for additional reimbursement over and above the daily rate for certain services. For the items listed below, identify the revenue accrued by your facility for the services provided during the cost reporting period and where the revenues were reported in this cost report (should be included on schedules 14 through 18).

On lines 1 and 2, the amounts reported should only reflect the revenues in excess of the Medicaid daily rate for residents' levels of care and for which the related expenses are included in this cost report.

On line 2, report the amount of reimbursement form the Medicaid program for specialized services (active treatment) for mentally ill residents who were determined to be in need of such services by a level II pre-admission screening and annual resident review.

| | Medicaid Revenue Item | Revenue Amount | Location in Cost Report: Schedule | Location in Cost Report: Line |
|---|---|---|---|---|
| 1. | Personalized durable medical equipment including Clinitron beds and motorized wheelchairs…….. | | | |
| 2. | Specialized services for the mentally ill…..……. | | | |
| 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…… | | | |
| **4.** | **TOTAL MISCELLANEOUS MEDICAID NON-RATE REVENUES (sum 1-7) . . . . . .** | **$-** | | |

**Medicaid PopID & Provider Number** 371-20191500

# SCHEDULE 53 - INCENTIVES - PRIVATE ROOM & PROPERTY

**PRIVATE ROOM INCENTIVE INSTRUCTIONS:** Based on the information provided in the cost report, your facility may qualify for the Basic Private Room Incentive (BPRI) or Replacement Private Room Incentive (RPRI) as explained in Section 2.720 of the Methods of Implementation. A facility may receive only one of the two private room incentives. A facility will qualify for the BPRI if it has exceptional Medicaid/Medicare utilization and at least 15% of the total beds are licensed for singel occupancy. A facility will qualify for the RPRI if it has exceptional Medicaid/Medicare utilization and has replaced 100% of patient rooms after July 1, 2000.

**Indicate if your facility is requesting a private room incentive**

[X] YES, my facility is requesting a private room incentive. If YES specify one and continue: [X] BPRI [ ] RPRI

[ ] YES, I am requesting RPRI and my facility has replaced 100% of patient rooms after July 1, 2000.

[ ] NO, my facility is not requesting the BPRI or RPRI.

If your facility is requesting one of the incentives, you must complete the affidavit below and return it to the Department by July 1, 2019, to qualify for one of the private room incentives.

## AFFIDAVIT

I HEREBY ATTEST and affirm that from July 1, 2020, to June 30, 2021, the The Pavilion at Glacier Valley 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 Basic Private Room Incentive (BPRI) or Replacement Private Room Incentive (RPRI) may be recouped retroactive to July 1, 2020, if the facility has charged Medicaid residents for private rooms during this period.

| **SIGNATURE -** Original Signature of Officer or Administrator of Nursing Home | Title | Date |
|---|---|---|
| | | |

## PROPERTY INCENTIVE:

Did the facility get approval for innovative property incentive on or after 7/1/12? See Sec. 3.655 of Methods of Implemenation [ ] YES [X] NO

ATTACH COPY OF INCENTIVE APPROVAL

Did the facility get approval prior to 7/1/12 for $10 per patient day for "Innovative Area:? See Sec. 4.920 of Methods of Implementation [ ] YES [X] NO

If YES to either question above - Complete the Following:

Date Approval Received: _____

Has Construction Begun? [ ] YES [ ] NO If YES, when did it begin? _____

Has construction been completed [ ] YES [ ] NO If completed, when was it completed? _____

Number of beds in Replacement Facility or "Innovative Area" _____

During this cost report period -

Number of Medicaid Fee For Service Patient days in Replacement Facility or "Innovative Area"? _____

Number of Medicaid Family Care Patient days in Replacement Facility or "Innovative Area"? _____

Numver of Medicaid Partnership Patient days in Replacement Facility or "Innovative Area"? _____