

**WISCONSIN MEDICAID PROGRAM 2018 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 East Troy Manor		Main Telephone Number 262-642-3995		Main E-Mail Address ekarls@carriagehealthcare.com	
Facility Street Address 3271 North Street		City East Troy		State WI	Zip Code 53120
Contact Person Emily Karls		Contact Telephone Number 262-642-3995		Contact E-Mail Address ekarls@carriagehealthcare.com	
Corporate Facility Number		Cost Report Period Start Date 1/1/2018		Cost Report Period End Date 12/31/2018	
Medicaid Provider Number 100001844		National Provider Identifier (NPI) 1043463963		POP ID Number 388	
Administrator Emily Karls		Chief Financial Officer		Where are the financial records of the nursing home located? East Troy	

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

Name and Title JT and Associates, LLC			Telephone Number 262-789-9945		
Address 700 Pilgrim Pkwy, Suite 200			City Elm Grove		State WI
Zip Code 53122			Date Signed		
SIGNATURE - Original Signature of Preparer					

**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**

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**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.

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Commentator's Name	Title	Date
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### SCHEDULE 3 - GENERAL INFORMATION

1. Type of Medicaid certification (check all that apply)	<input checked="" type="checkbox"/> (01) Nursing Facility	<input type="checkbox"/> (10) ICF-IID	
2. Type of license (check all that apply)	<input checked="" type="checkbox"/> (01) Skilled Nursing	<input type="checkbox"/> (20) Developmentally Disabled	
	<input type="checkbox"/> (10) Intermediate Care	<input type="checkbox"/> (40) IMD	
3. Type of ownership (check one)	<input type="checkbox"/> (1) Proprietary	<input checked="" type="checkbox"/> (2) Voluntary Non-Profit	<input type="checkbox"/> (3) Governmental

4. County of facility <b>Walworth</b>	County Code <b>64</b>
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5. Does the facility self-fund any of the fringe benefits reported on schedule 28? If yes, provide documentation to support the amount claimed.	<input type="checkbox"/> (1) Yes	<input checked="" type="checkbox"/> (2) No
6. Does the facility provide laundry services to residents for personal clothing?	<input checked="" type="checkbox"/> (1) Yes	<input type="checkbox"/> (2) No
7. Are any employees of the facility covered by a union contract?	<input type="checkbox"/> (1) Yes	<input checked="" type="checkbox"/> (2) No
8. Is the facility Medicare (Title XVIII) certified?	<input checked="" type="checkbox"/> (1) Yes	<input type="checkbox"/> (2) No

9. Fiscal Year Beginning Month <b>Jan</b>	Fiscal Year Ending Month <b>Dec</b>
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10. List the number of licensed beds at the beginning and end of your cost reporting period. Do not include restricted beds.

	DATE	BEDS
Beds at Beginning of Cost Reporting Period	1/1/2018	50
Beds at End of Cost Reporting Period	12/31/2018	50
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.	_____	_____
_____	_____	_____

11. Has a certified audit been conducted for the cost reporting period? If yes, submit complete report copy including notes to the financial statements.	<input checked="" type="checkbox"/> (1) Yes	<input type="checkbox"/> (2) No
12. Check all related party transaction types for which expenses are reported.	<input type="checkbox"/> (1) Related party lease of building	<input type="checkbox"/> (2) Compensation to owners/family relation
	<input type="checkbox"/> (3) Interest expense on related party loans	<input type="checkbox"/> (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?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> 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. East Troy Manor	2548	42	8	50
2. _____	_____	_____	_____	-
3. _____	_____	_____	_____	-
4. TOTAL .....		42	8	50

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

**SCHEDULE 5 - BUILDING SQUARE FOOTAGE**

<b>SECTION A - GENERAL INFORMATION</b>	<b>WING A</b>	<b>WING B</b>	<b>WING C</b>	<b>WING D</b>
Name or description of building or wing . . . . .	SNF			
Year construction was functionally completed on building or wing . . . . .	1977			
Total square footage of building or wing . . . . .	20,020			
<b>SECTION B - NURSING HOME SERVICE AREAS</b>				
1. Nuns or other employees' housing . . . . .				
2. Employees' unique fringe benefit areas . . . . .				
3. Dietary (kitchen, food preparation & storage, dish washing, kitchen cleanup) . . . . .				
4. Plant equipment (furnace/boiler room, electrical, water, similar plant equip.) . . . . .				
5. Laundry (washing/drying room, sorting/folding rooms, central linen storage) . . . . .				
6. Administration (general/accounting offices, reception areas, meeting rooms) . . . . .				
7. Laboratory & radiology . . . . .				
8. Pharmacy . . . . .				
9. Physical therapy . . . . .				
10. Occupational therapy . . . . .				
11. Other therapies . . . . .				
12. Beauty and barber shops . . . . .				
13. Gift shop, canteen, snack shop . . . . .				
14. Patient areas (rooms, bathrooms, halls, nurse desk/office, dayrooms, rec.) . . . . .	20,020			
<b>SECTION C - RENTED AND OTHER MAJOR REVENUE ACTIVITY AREAS (SEE SCHEDULE 4). IDENTIFY EACH ACTIVITY</b>				
15. Hospital direct patient service areas . . . . .				
16. _____				
17. _____				
18. _____				
<b>SECTION D - OTHER AREAS</b>				
19. Major idle or closed areas . . . . .				
20. Residual unidentified square footage (Total area less lines 1 through 19) . . . . .				
Describe general purpose or use of Line 20 square footage: _____				

**SCHEDULE 6 - TOTAL PATIENT DAYS**

	LEVEL OF CARE (LOC)		TOTAL
	NON DD	DD	
1a. Medicaid (T-19) .....	7,751		7,751
1b. ICF-IID Medicaid (T-19) .....			-
1c. Family Care (T-19) .....	599		599
1d. Other Medicaid Managed Care (T-19) .....			-
1e. Hospice (T-19) .....	1,576		1,576
1f. Ventilator (T-19) .....			-
2a. Medicare (T-18) .....	994		994
2b. Medicare Advantage, for days covered as a Part A stay	986		986
3a. Private pay & Insurance .....	2,569		2,569
3b. Medicare Advantage, for days not covered as a Part A stay	901		901
3c. Hospice (Private pay & Insurance)			-
4. Other, Specify: _____			
5. TOTAL INHOUSE PATIENT DAYS .....	15,376	-	15,376

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

SECTION C - TOTAL PATIENT DAYS			
	NON DD	DD	TOTAL
9. TOTAL DAYS (lines 5 + 8) .....	15,376	-	15,376

**SCHEDULE 7 - NO LONGER USED**

Information is now on Schedule 6

**SCHEDULE 8 - TOTAL PATIENT DAYS BY MONTH**

(Required)

1. MONTH . . . . .	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	TOTAL
2. Days in Month . . . . .	31	28	31	30	31	30	31	31	30	31	30	31	365
Licensed Beds for Bed Hold													
3. Testing . . . . .	50	50	50	50	50	50	50	50	50	50	50	50	600
4. Occupancy Test:													
Row 2 X (Row 3 X 94%)	1,457	1,316	1,457	1,410	1,457	1,410	1,457	1,457	1,410	1,457	1,410	1,457	17,155
5. Inhouse patient days	1,295	1,128	1,288	1,319	1,273	1,321	1,369	1,388	1,242	1,294	1,208	1,251	15,376
6. Bed Hold days . . . . .	-	-	-	-	-	-	-	-	-	-	-	-	-
7. <b>TOTAL DAYS . . . . .</b>	<b>1,295</b>	<b>1,128</b>	<b>1,288</b>	<b>1,319</b>	<b>1,273</b>	<b>1,321</b>	<b>1,369</b>	<b>1,388</b>	<b>1,242</b>	<b>1,294</b>	<b>1,208</b>	<b>1,251</b>	<b>15,376</b>

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







**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	\$ 5,242,867
2. Service fees	schedule 15, line 14A	609,857
3. Rent from outside medical providers	schedule 15, line 14B	-
4. Other	schedule 15, line 14C	-
5. Dietary revenues	schedule 16, line 5A	219
6. Miscellaneous services and materials revenue	schedule 16, line 16	6,426
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	14,982
14. Other revenue	schedule 18, line 54	10,422
15. Subtract: deductions from revenues	schedule 14, line 5	( 2,067,436 )
16. NET REVENUES		\$ 3,817,337

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

17. Subtract: total expenses	schedule 12, line 38	\$ ( 3,931,565 )
18. Add or subtract the amount to adjust related party transactions to cost	schedule 42, line 15	9,721
19. NET INCOME OR LOSS		\$ (104,507)

NURSING HOME COST REPORT SCHEDULE 11

**SCHEDULE 12 - SUMMARY OF TOTAL EXPENSES**

All values are automatically posted from other schedules.

Cost Center	Reference	Expense	Cost Center	Reference	Expense
1. Daily patient service expense . . . . .	S20, L10	\$ 1,202,172	20. Transportation . . . . .	S25, L19f	\$ -
2. Laboratory & Radiology . . . . .	S21, L15a	10,459	21. Administrative service expense . . . . .	S26, L12	671,468
3. Respiratory . . . . .	S21, L15b	-	Other cost centers, Specify:		
4. Pharmacy . . . . .	S21, L15c	72,080	22. Nurse Aide Training	S27, L15a	
5. PT, OT and Speech . . . . .	S22, L15a	267,775	23. Beauty/Barber Shop	S27, L15b	5,676
6. Dental . . . . .	S22, L15b	-	24. 0	S27, L15c	
7. Physician . . . . .	S22, L15c	12,300	25. 0	S27, L15d	
8. Social Services . . . . .	S23, L15a	63,841	26. 0	S27, L15e	
9. Recreational Activities . . . . .	S23, L15b	77,492	UNASSIGNED EXPENSES		
10. Religious Services . . . . .	S23, L15c	-	27. Employee fringe benefit expense . . . . .	S28, L17	285,245
11. Volunteer Coordinator . . . . .	S24, L15a	-	28. Heating fuel and utility expense . . . . .	S29, L10	99,802
12. Ward Clerks . . . . .	S24, L15b	-	29. Interest on operating working capital loans	S30, L6	6,178
13. Psychotherapy . . . . .	S24, L15c	-	30. Insurance expense . . . . .	S31, L9	24,817
14. Other . . . . .	S24, L15d	-	31. Amortization expense . . . . .	S32, L5	94,535
15. Dietary . . . . .	S25, L19a	369,170	32. Interest on plant asset loans . . . . .	S33, L15h	263,485
16. Plant Operations and Maintenance . . . . .	S25, L19b	106,032	33. Depreciation expense . . . . .	S34, L20c	195,643
17. Housekeeping . . . . .	S25, L19c	69,316	34. Expense on operating and non-cap.leases	S35, L14	16,472
18. Laundry and Linen . . . . .	S25, L19d	17,607	35. Expense on capitalized leases . . . . .	S36A, L5	-
19. Security . . . . .	S25, L19e	-	36. Property tax expense . . . . .	S37, L9	-
			37. Other non-salary expense . . . . .	S39, L4	-
			<b>38. TOTAL EXPENSES FOR REPORT PERIOD (Sum 1-38) . .</b>		<b>\$ 3,931,565</b>

(To schedule 11, line 17)

**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	\$ 1,099,646	Dietary . . . . .	S25, L1a	253,663
Laboratory & Radiology . . . . .	S21, L1a	-	Plant operation / maintenance . . . . .	S25, L1b	51,677
Respiratory . . . . .	S21, L1b & 3b	-	Housekeeping . . . . .	S25, L1c	58,867
Pharmacy . . . . .	S21, L1c & 3c	-	Laundry and Linen . . . . .	S25, L1d	12,960
PT, OT and Speech . . . . .	S22, L1a & 3a	232,091	Security . . . . .	S25, L1e	-
Dental . . . . .	S22, L1b & 3b	-	Transportation . . . . .	S25, L1f	-
Physician . . . . .	S22, L1c & 3c	-	Administrative service . . . . .	S26, L1e	237,648
Social Services . . . . .	S23, L3a	63,841	Nurse aide training . . . . .	S27, L1a	-
Recreational Activities . . . . .	S23, L3b	67,514	Beauty and barber . . . . .	S27, L1b	5,676
Religious Services . . . . .	S23, L3c	-	Other, Specify: 0	S27, L1c	-
Volunteer Coordinator . . . . .	S24, L1a & 3a	-	0		-
Ward Clerks . . . . .	S24, L1b & 3b	-	0		-
Psychotherapy . . . . .	S24, L1c & 3c	-			
Other . . . . .	S24, L1d & 3d	-	<b>TOTAL SALARY AND WAGE EXPENSE . . . . .</b>		<b>\$ 2,083,583</b>

### 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**

	<b>Revenue</b>
1. Medicare Daily Rate	\$920,894
2. Medicaid Daily Rate (including bed hold)	3,198,242
3. Private Pay	1,123,731
4. Medical Supplies, Other	_____

**SECTION B - Deductions From Revenue**

5. TOTAL DEDUCTIONS FROM REVENUE ( 2,067,436 )

**SECTION C - TOTAL**

6. TOTAL DAILY PATIENT SERVICE REVENUE \$ 3,175,431

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

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

**Average Daily Private Pay Rate**

7. Average Daily \$315.00

8. Facility Comment (Optional) \_\_\_\_\_

### 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 . . . . .	\$ 9,165			
2. Radiology . . . . .	1,364			
3. Pharmacy . . . . .	123,088			
4. Physical therapy . . . . .	247,786			
5. Speech/hearing therapy . . . . .	24,254			
6. Occupational therapy . . . . .	204,200			
7. Physician care . . . . .				
8. Psychotherapy . . . . .				
9. Respiratory therapy				
10. Social services . . . . .				
11. Recreational activities . . . . .				
12. Special duty nursing . . . . .				
13. Other, Specify: _____				
14. TOTAL SPECIAL SERVICE REVENUE . .	<b>\$ 609,857</b>	<b>\$ -</b>	<b>\$ -</b>	

If totals exceed \$4,000, see instructions above.

#### SECTION B - THERAPY REVENUES

15. Are physical, occupational, or speech therapy services provided by staff, assistants, contractors, or consultants IN SPACE AT YOUR FACILITY?  Yes  No
16. Total gross revenues for physical, occupational, and speech therapy services provided at your facility during the cost report period \$ 476,240  
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) \$ 476,240
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  No If yes, amount of revenue \_\_\_\_\_
20. Does your facility or related organization bill Medicare Part B for therapy services at your facility?  Yes  No If yes, amount of revenue \$ 93,188
21. Did you charge rent to a rehabilitation agency or independent contractor?  Yes  No If yes, amount of revenue \_\_\_\_\_

**SCHEDULE 16 - OTHER REVENUES**

**SECTION A - CAFETERIA AND DIETARY REVENUE**

1. Donated and surplus food commodities .....	_____	Included in food supply expense for donated/surpl	_____
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 .....	219		
<b>5a. TOTAL DIETARY REVENUE .....</b>	<b>\$ 219</b>		

**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 .....	6,143	5,676	Other	27	1
10. Gift Shop .....	_____	_____	_____	_____	_____
11. Canteen and snack counter .....	_____	_____	_____	_____	_____
12. Vending machines .....	283	_____	_____	_____	_____
13. Sale of clothing .....	_____	_____	_____	_____	_____
14. Television and cable service .....	_____	_____	_____	_____	_____
15. Telephone and Internet .....	_____	_____	_____	_____	_____
<b>16. TOTAL MISCELLANEOUS SERVICES AND MATERIALS</b>	<b>\$ 6,426</b>	_____	_____	_____	_____

**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.

<b>SECTION C - RENTAL REVENUE</b>				
	<b>Revenue</b>	<b>Property Rented</b>	<b>Square Feet Rented</b>	<b>Services Provided</b>
18. Equipment rental .....	_____	_____	_____	_____
19. Rental of nursing home space .....	_____	_____	_____	_____
20. Rental of non-nursing home space .....	_____	_____	_____	_____
21. Parking .....	_____	_____	_____	_____
<b>21a. TOTAL RENTAL REVENUES .....</b>	<b>\$ -</b>			

<b>SECTION D - REVENUE FROM MAJOR ACTIVITIES</b>		
	<b>Revenue</b>	<b>Total Billable Patient Days if revenue generated from activities 24,25,26</b>
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. _____	_____	_____
<b>37. TOTAL REVENUE FROM OTHER MAJOR ACTIVITIES .....</b>	<b>\$ -</b>	



**SCHEDULE 18 - OTHER REVENUES**

<b>SECTION E - SALES TO RELATED ORGANIZATIONS</b>		<b>Revenue</b>	<b>SECTION H - GRANTS FOR GOVT. SUBSIDIZED EMP.</b>		<b>Revenue</b>
38.			48.	TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES . . . . .	
39.					
40.					
41.	TOTAL SALES TO RELATED ORGANIZATIONS	<b>\$ -</b>			
<b>SECTION F - INTEREST AND INVESTMENT REVENUE</b>		<b>Revenue</b>	<b>SECTION I - GRANTS, CONTRIBUTIONS, DONATIONS</b>		<b>Revenue</b>
42.	Revenues from invested gift/grant funds not commingled with other funds . . . . .		49.	TOTAL GRANTS, CONTRIBUTIONS, DONATIONS . . . . .	<b>\$ 14,982</b>
43.	Revenue from invested funds used for current cash needs . . . .				
44.	Other revenue from invested funds . . . . .				
45.	TOTAL INVESTMENT REVENUE . . . . .	<b>\$ -</b>			
46.	If total investment revenue exceeds \$6,000, describe major investments (type, invested amount, purpose if any)				
<b>SECTION G - GAINS (LOSSES) DISPOSAL OF ASSETS</b>		<b>Gain (Loss)</b>	<b>SECTION J - OTHER REVENUES</b>		<b>Revenue</b>
47.	TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS . . . . .		50.	Rebates	<b>\$ 3,755</b>
			51.	Misc Income	<b>6,667</b>
			52.		
			53.		
			54.	TOTAL OTHER REVENUES . . . . .	<b>\$ 10,422</b>

**SCHEDULE 20 - DAILY PATIENT SERVICE EXPENSE**

<b>SALARIES, WAGES PURCHASED SERV.</b>	<b>A. Registered Nurses</b>	<b>B. Licensed Practical Nurses</b>	<b>C. Nurse Aides and Assistants</b>	<b>D. Resident Living Staff</b>	<b>E. Total Expense/Hrs. (sum A-D)</b>
1. TOTAL SALARY AND WAGE EXPENSE	\$ 275,427	\$ 288,803	\$ 535,416		\$ 1,099,646
2. TOTAL SALARY AND WAGE HOURS	9,261 hrs.	11,934 hrs.	49,905 hrs.		\$ 71,100
3. EXPENSE FOR PURCHASED SERVICES	\$ 2,030		\$ 17,936		\$ 19,966
<b>NURSING AND INCONTINENCY SUPPLIES</b>					
4. Catheters, Incontinency Supplies (including purchased laundry service)					
<b>OXYGEN</b>					
5. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental					2,411
<b>OTHER</b>					
6. Other medical supplies, personal comfort supplies and minor medical equipment					70,519
7. Nonbillable over the counter (OTC) drugs for all residents (include other OTC drugs billable on drug claim forms schedule 21, line 11)					9,630
8. _____					
9. _____					
10. <b>TOTAL DAILY PATIENT SERVICE EXPENSE (Sum 1, 3, 4-9)</b>					<b>\$ 1,202,172</b>

**SCHEDULE 21 - SPECIAL SERVICE EXPENSES**

	TYPE OF SERVICE		
	A. Laboratory & Radiology	B. Respiratory	C. Pharmacy
<b>SECTION A - SALARY AND WAGES</b>			
1. Expense for hours worked - Billable			
2. Number of hours worked - Billable			
3. Expense for hours worked - Non-billable	\$ -		
4. Number of hours worked - Non-billable	hrs.		
5. TOTAL SALARY AND WAGE EXPENSE	\$ -	\$ -	\$ -
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable	\$ 10,459		
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.		
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
10. Pharmacy - legend drugs Billable	\$ -	\$ -	72,080
11. Pharmacy - over the counter drugs Billable	\$ -	\$ -	
12. Supply and Other			
13.			
14.			
<b>SECTION D - TOTAL</b>			
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14)	\$ 10,459	\$ -	\$ 72,080
16. TOTAL HOURS (Sum 2, 4, 7, 9)	hrs.	hrs.	hrs.

**SCHEDULE 22 - SPECIAL SERVICE EXPENSES**

	TYPE OF SERVICE		
	A. Physical, Occupational And Speech Therapy	B. Dental	C. Physician
<b>SECTION A - SALARY AND WAGES</b>			
1. Expense for hours worked - Billable.....	\$ 232,091		
2. Number of hours worked - Billable.....	6,342 hrs.		
3. Expense for hours worked - Non-billable.....			
4. Number of hours worked - Non-billable.....			
5. TOTAL SALARY AND WAGE EXPENSE	\$ 232,091	\$ -	\$ -
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable.....			
7. Number of hours of purchased service - Billable (optional).....			
8. Expense for purchased service - Non billable.....	\$ 35,420		\$ 12,300
9. Number of hours of purchased service - Non billable (optional).....			
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
10. Supplies.....	264		
11. ....			
12. ....			
13. ....			
14. ....			
<b>SECTION D - TOTAL</b>			
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14).....	\$ 267,775	\$ -	\$ 12,300
16. TOTAL HOURS (Sum 2, 4, 7, 9).....	6,342 hrs.	hrs.	hrs.

**SCHEDULE 23 - SPECIAL SERVICE EXPENSES**

	TYPE OF SERVICE		
	A. Social Services	B. Recreational Activities	C. Religious Services
<b>SECTION A - SALARY AND WAGES</b>			
1. Expense for hours worked - Billable	\$ -	\$ -	\$ -
2. Number of hours worked - Billable	hrs.	hrs.	hrs.
3. Expense for hours worked - Non-billable	\$ 63,841	\$ 67,514	
4. Number of hours worked - Non-billable	2,160 hrs.	5,992 hrs.	
5. TOTAL SALARY AND WAGE EXPENSE	\$ 63,841	\$ 67,514	\$ -
<b>SECTION B - PURCHASED SERVICES</b>			
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			
9. Number of hours of purchased service - Non billable (optional)			
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
10. Supplies		\$ 9,978	
11. _____			
12. _____			
13. _____			
14. _____			
<b>SECTION D - TOTAL</b>			
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14)	\$ 63,841	\$ 77,492	\$ -
16. TOTAL HOURS (Sum 2, 4, 7, 9)	2,160 hrs.	5,992 hrs.	hrs.

**SCHEDULE 24 - OTHER TYPES OF SPECIAL SERVICE EXPENSES**

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

**SCHEDULE 25 - GENERAL SERVICE EXPENSES**

**SECTION A - SALARIES AND WAGES**

	<u>A. Dietary</u>	<u>B. Plant Op./Maint.</u>	<u>C. Housekeeping</u>	<u>D. Laundry / Linen</u>	<u>E. Security</u>	<u>F. Transportation</u>
1. TOTAL SALARY AND WAGE EXPENSE	\$ 253,663	\$ 51,677	\$ 58,867	\$ 12,960		
2. NUMBER OF HOURS WORKED	19,671 hrs.	2,644 hrs.	5,661 hrs.	918 hrs.		

Lines 3-5 are no longer used

**SECTION B - DIETICIAN CONSULTANT**

6. Dietician consultant expense	\$ 3,464	\$ -	\$ -	\$ -	\$ -	\$ -
---------------------------------	----------	------	------	------	------	------

Line 7 is no longer used

**SECTION C - OUTSIDE SERVICE**

8. Purchased Services		\$ 38,569				
9.						
10.						
11.						
12. TOTAL OUTSIDE SERVICE EXPENSES	\$ -	\$ 38,569	\$ -	\$ -	\$ -	\$ -

**SECTION D - No longer used**

**SECTION E - SUPPLY AND OTHER EXPENSE**

13. Food	\$ 102,645					
14. Supplies	9,398	15,786	10,449	4,647		
15.						
16.						
17.						

**SECTION F - No longer used**

**SECTION G - TOTAL**

18. TOTAL EXPENSES	\$ 369,170	\$ 106,032	\$ 69,316	\$ 17,607	\$ -	\$ -
(Sum 1, 6, 8-11, 13-17)						

**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)	\$	369,170
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)	\$	369,170

	A. Total	B. Residents'	C. Employees'	D. Meals on	E. Other	F. Other
	_____	_____	_____	_____	_____	_____
	Meals	Meals	Meals	Wheels	Guests	_____
6. Meals served	46,614	46,128	102	_____	384	_____
7. Ratio to total meals served to 4 decimals	1.0000	0.9896	0.0022	_____	0.0082	_____
8. DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	\$ 369,170	\$ 365,331	\$ 812	\$ -	\$ 3,027	\$ -
	<small>From line 5</small>	<small>8A X 7B</small>	<small>8A X 7C</small>	<small>8A X 7D</small>	<small>8A X 7E</small>	<small>8A X 7F</small>
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)			\$ 812			

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

	A. Total	B. Nursing Home	C. Emp. Unique	Non-Nursing Home Areas w/ Plant Operation and Maint.		
	_____	_____	_____	D.	E.	F.
	Area	Area	Fringe Benefit Area	_____	_____	_____
12. Total square feet for areas	20,020	20,020	_____	_____	_____	_____
13. Ratio to total square feet to 4 decimals . . .	1.0000	1.0000	_____	_____	_____	_____
14. TOTAL PATIENT OP/MAINT EXP. ALLOC.	\$ 106,032	\$ 106,032	\$ -	\$ -	\$ -	\$ -
	<small>From S25, L18</small>	<small>14A X 13B</small>	<small>14A X 13C</small>	<small>14A X 13D</small>	<small>14A X 13E</small>	<small>14A X 13F</small>



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

**SECTION A - ALLOCATION OF HOUSEKEEPING EXPENSES**

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

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			
15. Square feet or hours of service provided	20,020	20,020			
16. Ratio to total sq. ft./hours to 4 decimals	1.0000	1.0000			
17. TOTAL HOUSEKEEPING EXP. ALLOC.	\$ 69,316	\$ 69,316	\$ -	\$ -	\$ -
	<small>From S25, L18</small>	<small>17A X 16B</small>	<small>17A X 16C</small>	<small>17A X 16D</small>	<small>17A X 16E</small>

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

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

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			
18. Pounds of laundry processed	-	-			
19. Ratio to total pounds to 4 decimals . . . . .	1.0000				
20. TOTAL LAUNDRY/LINEN EXP. ALLOC.	\$ 17,607	\$ -	\$ -	\$ -	\$ -
	<small>From S25, L18</small>	<small>20A X 19B</small>	<small>20A X 19C</small>	<small>20A X 19D</small>	<small>20A X 19E</small>

**SECTION C - ALLOCATION OF SECURITY EXPENSES**

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

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

**SECTION D - ALLOCATION OF TRANSPORTATION EXPENSES**

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

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			
24. Alloc. Basis, Specify: _____	-				
25. Ratio to total alloc. basis to 4 decimals	1.0000				
26. TOTAL TRANS. EXPENSE ALLOC.		\$ -	\$ -	\$ -	\$ -
	<small>From S25, L18</small>	<small>26A X 25B</small>	<small>26A X 25C</small>	<small>26A X 25D</small>	<small>26A X 25E</small>

**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.

<b>SECTION A - SALARY AND WAGES</b>	<b>A. General Admin. Serv.</b>	<b>B. Medical Records</b>	<b>C. Central Supply</b>	<b>D. Accounting/Other Serv.</b>	<b>E. TOTAL (sum A-D)</b>
1. TOTAL SALARY AND WAGE EXPENSE . . . . .	\$ 237,648				\$ 237,648

**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	\$ 5,978
9. Licensed bed assessment	102,000
10. Contractual management fees	149,120
11. Total other non-salary (from schedule 26 attachment)	176,722

**SECTION D - TOTAL**

12. TOTAL ADMINISTRATIVE SERVICE EXPENSES (Sum 1, 6-11)	\$ 671,468
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**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) \_\_\_\_\_

**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.

<b>SECTION A - SALARY AND WAGES</b>	<b>A. General Admin. Serv.</b>	<b>B. Medical Records</b>	<b>C. Central Supply</b>	<b>D. Accounting/Other Serv.</b>	<b>E. TOTAL (sum A-D)</b>
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)	_____ 27,559

**SECTION D - TOTAL**

12. TOTAL ADMINISTRATIVE SERVICE EXPENSES (Sum 1, 6-11)	\$ _____ 27,559
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**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) \_\_\_\_\_

### 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. Owner Fees	\$ 37,280
2. Fines & Penalties	34,076
3. Supplies	3,978
4. Business Travel	1,738
5. Help Wanted Advertising	1,025
6. Marketing	2,654
7. Bank Charges	6,631
8. Dues & Subscription	2,376
9. Professional Fees	32,487
10. Employee Education/Seminars	9,896
11. Data Processing	40,921
12. Employee Recruitment Expense	1,741
13. Postage	1,193
14. Telephone	726
15.	
<b>16. TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (Should equal schedule 26, line 11) . . . . .</b>	<b>\$ 176,722</b>

**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. Home Office Costs	\$ 27,559
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____
16. <b>TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (Should equal schedule 26, line 11)</b> .....	<b>\$ 27,559</b>

**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) \$ 671,468

**SECTION A - DIRECT EXPENSES**

Exp. Directly Ascribable To Each Activity	Non-Nursing Home Areas Receiving Administrative Services				
	A. Total	B. NH Provider			
2. All to SNF	\$ (671,468)	\$ 671,468			
3.	-				
4.	-				
5.	-				
6.	-				
7.	-				
8.	-				
9.	-				
10.	-				
11.	-				
12.	-				
13.	-				
14.	-				
15. TOTAL DIRECT EXP. (sum 2-14)	\$ (671,468)	\$ 671,468			
16. NET UNASSIGNED EXP. (line 1-line 15)	\$ -				

**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	\$ -	\$ -	\$ -	\$ -	\$ -
	net from line 16	19A X 18B	19A X 18C	19A X 18D	19A X 18E
20. TOTAL ADMINISTRATIVE EXPENSE	\$ 671,468	\$ 671,468	\$ -	\$ -	\$ -
	(line 15A + 19A)	B15 + B19	C15 + C19	D15 + D19	E15 + E19

**SCHEDULE 27 - OTHER COST CENTERS**

<b>SECTION A - SALARY AND WAGES</b>		<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>			
1.	TOTAL SALARY AND WAGE EXPENSE		\$ 5,676			
2.	NUMBER OF HOURS WORKED		472 hrs.			
<hr/>						
<b>SECTION B - NON-SALARY EXPENSES</b>		<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>			
3.				-	-	-
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.	<b>TOTAL NON-SALARY EXPENSES</b>	\$ -	\$ -	\$ -	\$ -	\$ -
<hr/>						
<b>SECTION C - TOTAL</b>		<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>			
16.	TOTAL EXPENSES (Sum 1, 3-14) . . . . .		\$ 5,676			

**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 Self Funded 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.		\$ 153,968
2. State unemployment compensation		9,142
3. Federal unemployemnt compensation		
4. Worker's compensation insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	50,546
5. Health, Dental & Vision Insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	59,715
6. Life and disability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	3,594
7. Wage continuation insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Pension and deferred comp. plans (section C)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	7,746
9. Employee physicals and vaccines (if pre-employment, report costs on Sch 26-Attachment)		95
10. Uniforms		
11. <u>Other Employee Benefits</u>		439
12. _____		
13. _____		
14. _____		
15. TOTAL PAID ON BEHALF OF EMPLOYEES (sum 1-14)		\$ 285,245
16. Expense for special salary or wage payments to employees not included elsewhere (section D)		
17. <b>TOTAL FRINGE BENEFIT EXPENSE(sum 15+16)</b>		<b>\$ 285,245</b>

**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     
  Other, Specify: \_\_\_\_\_

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	East Troy Manor				
Cost Report Period	1/1/2018	12/31/2018			
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
<i>Checked as self-funded on Sch 28?</i>					
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)	\$ -	\$ -	\$ -	\$ -	\$ -

### 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**

	Accrued Expense	Expense by Type		Accrued Expense
1. Fuel oil		6. Water and sewer utility charges		25,295
2. Natural gas	10,350	7. Purchased steam		
3. L.P. gas		8. _____		
4. Coal		9. _____		
5. Electricity	64,157	<b>10. TOTAL FUEL AND UTILITY EXPENSE . . .</b>	<b>\$</b>	<b>99,802</b>

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

	A. Total	B. NH Area	C. Emp. Unique Fringe Ben. Area	Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv.		
11. Total square feet for areas	20,020	20,020				
12. Ratio to total square feet to 4 decimals	1.0000	1.0000				
<b>13. TOTAL ALLOC. FUEL/UTIL. EXPENSE</b>	<b>99,802</b>	<b>\$ 99,802</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
	From line 10	13A X 12B	13A X 12C	13A X 12D	13A X 12E	13A X 12F

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

	Name of Lender	Is Lender a Related Party?	Interest Expense
1a.	Marlin/Advantage	b. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$ 6,178
2a.		b. <input type="checkbox"/> Yes <input type="checkbox"/> No	
3a.		b. <input type="checkbox"/> Yes <input type="checkbox"/> No	
4a.		b. <input type="checkbox"/> Yes <input type="checkbox"/> No	
5a.		b. <input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	<b>TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS (sum 1-5)</b>		<b>\$ 6,178</b>

### SCHEDULE 31 - INSURANCE EXPENSES

	Type of Insurance Coverage	Self-Funded?	Insurance Expense
1.	Property insurance on building and contents	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$ 4,695
2.	Automobile insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Liability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	20,122
4.	Business interruption insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	Life insurance on owners and employes with facility as the beneficiary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Mortgage insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	Other Property	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8.	Other General	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	<b>TOTAL INSURANCE EXPENSE</b>		<b>\$ 24,817</b>

### 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. Bond Closing Costs	\$ 34,243	2010	23	\$ 12,297	\$ -	\$ 12,297
2. Bond Closing Costs	80,285	2017	30	80,285	-	80,285
3. Bond Closing Costs	293,934	2018	30	293,934	291,981	1,953
4.						
5. <b>TOTAL AMORTIZATION EXPENSE</b>						<b>\$ 94,535</b>

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

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

**SCHEDULE 31 - INSURANCE EXPENSES - RELATED PARTY**

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

**SCHEDULE 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.	<b>TOTAL AMORTIZATION EXPENSE .....</b>					<b>\$ _____ -</b>

**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			G. Interest Rate	H. Interest Expense
				D. Begin date 1/1/2018 Begin Bal.	E. 6Mo.date 6/30/2018 6 Mo. Bal.	F. End date 12/31/2018 End Bal.		
1a. Name <u>Series 2010 &amp; 2014</u>								
1b. Related party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<u>May-10</u>	<u>Aug-36</u>	<u>\$ 5,762,900</u>	<u>\$ 5,450,752</u>	<u>\$ 5,450,752</u>	<u>\$ -</u>	<u>5.50%</u>	<u>\$ 184,786</u>
1c. Purpose <u>Remodeling</u>								
2a. Name <u>2018 Series</u>								
2b. Related party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<u>Aug-18</u>	<u>Aug-48</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 5,959,025</u>	<u>5.25%</u>	<u>\$ 78,699</u>
2c. Purpose <u>Remodeling/refinancing</u>								
3a. Name _____								
3b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
3c. Purpose _____								
4a. Name _____								
4b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
4c. Purpose _____								
5a. Name _____								
5b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
5c. Purpose _____								
6a. Name _____								
6b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
6c. Purpose _____								
7a. Name _____								
7b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
7c. Purpose _____								
<b>15 TOTAL LOAN PRINCIPAL .....</b>				<b><u>\$ 5,450,752</u></b>	<b><u>\$ 5,450,752</u></b>	<b><u>\$ 5,959,025</u></b>	<b>TOTAL EXP.....</b>	<b><u>\$ 263,485</u></b>

**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			G. Interest Rate	H. Interest Expense
				D. Begin date 1/1/2018 Begin Bal.	E. 6Mo.date 6/30/2018 6 Mo. Bal.	F. End date 12/31/2018 End Bal.		
8a. Name _____								
8b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
8c. Purpose _____								
9a. Name _____								
9b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
9c. Purpose _____								
10a. Name _____								
10b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
10c. Purpose _____								
11a. Name _____								
11b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
11c. Purpose _____								
12a. Name _____								
12b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
12c. Purpose _____								
13a. Name _____								
13b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
13c. Purpose _____								
14a. Name _____								
14b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
14c. Purpose _____								
16 TOTALS FOR SCHEDULE 33, PAGE 2 ONLY				\$ -	\$ -	\$ -		\$ -
<b>SEE SCHEDULE 33 FOR TOTAL LOAN PRINCIPAL OF SCHEDULE 33 AND SCHEDULE 33, PAGE 2</b>								

**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			G. Interest Rate	H. Interest Expense
				D. Begin date 1/1/2018 Begin Bal.	E. 6Mo.date 6/30/2018 6 Mo. Bal.	F. End date 12/31/2018 End Bal.		
1a. Name _____								
1b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
1c. Purpose _____								
2a. Name _____								
2b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
2c. Purpose _____								
3a. Name _____								
3b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
3c. Purpose _____								
4a. Name _____								
4b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
4c. Purpose _____								
5a. Name _____								
5b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
5c. Purpose _____								
6a. Name _____								
6b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
6c. Purpose _____								
7a. Name _____								
7b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
7c. Purpose _____								
<b>15 TOTAL RELATED PARTY LOAN PRINCIPAL</b> .....				<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>TOTAL EXP. ....</b>	<b>\$ -</b>

**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			G. Interest Rate	H. Interest Expense
				D. Begin date 1/1/2018 Begin Bal.	E. 6Mo.date 6/30/2018 6 Mo. Bal.	F. End date 12/31/2018 End Bal.		
8a. Name _____								
8b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
8c. Purpose _____								
9a. Name _____								
9b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
9c. Purpose _____								
10a. Name _____								
10b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
10c. Purpose _____								
11a. Name _____								
11b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
11c. Purpose _____								
12a. Name _____								
12b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
12c. Purpose _____								
13a. Name _____								
13b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
13c. Purpose _____								
14a. Name _____								
14b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> 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**



**SCHEDULE 34 - DEPRECIATION EXPENSES**

**SECTION A - CAPITALIZED HISTORICAL COST**

	Begin Date <u>1/1/2018</u>	C. Additions During Report	D. Disposals During Report	End Date <u>12/31/2018</u>
	B. Beginning Balance	Period	Period	E. Ending Balance
1. Land	200,000		( )	\$ 200,000
2. Land Improvements	59,620		( )	59,620
3. Buildings	5,028,786	28,822	( )	5,057,608
4. Leasehold Improvements			( )	-
5. Fixed equipment			( )	-
6. Moveable equipment	487,694	4,979	( )	492,673
7. Transportation vehicles	15,288		( )	15,288
8. _____			( )	-
9. _____			( )	-
10. TOTAL CAPITALIZED COST . .	<b>\$ 5,791,388</b>	<b>\$ 33,801</b>	<b>( \$ - )</b>	<b>\$ 5,825,189</b>

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

	A. Depreciation	Begin Date <u>1/1/2018</u>	C. Depreciation Exp.	D. Removal of Accum.	End Date <u>12/31/2018</u>
	Method, Lives Used	B. Beginning Balance	During Report Period	Deprec. On Disposals.	E. Ending Balance
11. Land Improvements		\$ 5,714	\$ 2,981	( )	\$ 8,695
12. Buildings		761,953	151,996	( )	913,949
13. Leasehold Improvements				( )	-
14. Fixed equipment				( )	-
15. Moveable equipment		239,570	40,666	( )	280,236
16. Transportation vehicles		15,288		( )	15,288
17. _____				( )	-
18. _____				( )	-
19. TOTAL ACCUMULATED DEPRECIATION		<b>\$ 1,022,525</b>		<b>( \$ - )</b>	<b>\$ 1,218,168</b>
<b>20. TOTAL DEPRECIATION EXPENSE</b>			<b>\$ 195,643</b>		

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

**SCHEDULE 34 - DEPRECIATION EXPENSES - RELATED PARTY**

**SECTION A - CAPITALIZED HISTORICAL COST**

	Begin Date <u>1/1/2018</u>	C. Additions During Report	D. Disposals During Report	End Date <u>12/31/2018</u>
	B. Beginning Balance	Period	Period (as negative value)	E. Ending Balance
1. Land			( )	\$ -
2. Land Improvements			( )	-
3. Buildings			( )	-
4. Leasehold Improvements			( )	-
5. Fixed equipment			( )	-
6. Moveable equipment			( )	-
7. Transportation vehicles			( )	-
8. _____			( )	-
9. _____			( )	-
10. TOTAL CAPITALIZED COST . . .	\$ -	\$ -	( \$ - )	\$ -

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

	A. Depreciation	Begin Date <u>1/1/2018</u>	C. Depreciation Exp.	D. Removal of Accum.	End Date <u>12/31/2018</u>
	Method, Lives Used	B. Beginning Balance	During Report Period	Deprec. On Disposals.	E. Ending Balance
11. Land Improvements				( )	\$ -
12. Buildings				( )	-
13. Leasehold Improvements				( )	-
14. Fixed equipment				( )	-
15. Moveable equipment				( )	-
16. Transportation vehicles				( )	-
17. _____				( )	-
18. _____				( )	-
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

### SCHEDULE 35 - LEASE EXPENSES ON OPERATING LEASES AND NON-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, 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. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____

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

A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (If known)	E. Month, Year acquired use	F. Describe Property	G. Lease Exp.
4. <u>GFC</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	May-16	Copiers	\$ 8,734
5. <u>TCF Financial</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	Nov-13	Van	6,833
6. <u>TCF Financial</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	Dec-18	Van	905
7. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
8. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
9. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
10. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
11. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
12. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
13. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____

**SECTION C - TOTAL**

14. TOTAL LEASE EXPENSE ON OPERATING LEASES AND NON-CAPITALIZED LEASES (sum 1-13) \$ 16,472

### 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? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No Beginning Lease Date _____ Ending Lease Date _____ Is this a lease purchase agreement? <input type="checkbox"/> Yes <input type="checkbox"/> 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? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No Beginning Lease Date _____ Ending Lease Date _____ Is this a lease purchase agreement? <input type="checkbox"/> Yes <input type="checkbox"/> 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? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No Beginning Lease Date _____ Ending Lease Date _____ Is this a lease purchase agreement? <input type="checkbox"/> Yes <input type="checkbox"/> 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? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No Beginning Lease Date _____ Ending Lease Date _____ Is this a lease purchase agreement? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	<b>TOTAL CAPITALIZED LEASE EXPENSE FOR REPORTING PERIOD - Transfer to Schedule 12 (sum 1d+2d+3d+4d) . . . . .</b>	<b>\$ _____ -</b>

**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? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> 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? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> 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? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> 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? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No	D4. If yes, (schedule) _____ (line) _____ (amount) _____
 E. <b>TOTAL CAPITALIZED LEASE PAYMENTS RELATED TO CAPITALIZED LEASES (sum A2+B2+C2+D2)</b> . . . . .	 <b>\$</b> _____ <b>-</b>

**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**

	<b>Expense</b>
1. 2018 real estate tax (due in 2019) relating to the nursing home operation (attach copy of bill or, if not yet received, send separately upon receipt.)	
2. 2018 personal property tax (due in 2019) 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? <input type="checkbox"/> Yes, go to question 3b <input type="checkbox"/> 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. 2016 or 2017? <input type="checkbox"/> Yes, explain below <input type="checkbox"/> No	
Tax year _____ Amount still outstanding _____ Tax year _____ Amount still outstanding _____	

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

	<b>Expense</b>
4. Amount of municipal service fee expense incurred by the nursing home appropriately accrued to calendar year 2018.	
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) <input type="checkbox"/> Prior to January 2018 <input type="checkbox"/> On or after January 2018 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) <input type="checkbox"/> Voluntary <input type="checkbox"/> Required by the tax authority	
<b>9. TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE</b> .....	<b>\$ -</b>

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. 2018 real estate tax (due in 2019) relating to the nursing home operation...
2. 2018 personal property tax (due in 2019) relating to the nursing home operation...
3a. Have the amounts reported on lines 1 and 2 been paid in full?
3b. Are there any real estate or personal property tax still outstanding from prior years...

SECTION B - FOR TAX-EXEMPT PROVIDERS ONLY

Expense

- 4. Amount of municipal service fee expense incurred by the nursing home...
5. Identify where municipal service fee expenses are reported in the cost report...
6. The facility began to pay municipal service fees (check one)...
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 \$ -

**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.

	<u>Nature and Source of Expense</u>	<u>Expense</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	<b>TOTAL OTHER NON-SALARY EXPENSES (sum 1 - 3)</b> .....	<b>\$ <u>          -</u></b>



**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.

	A. Total From Sched.	B. NH Service Area	Areas for Non-NH Serv. Or Other Major Revenue-Generating Activities		
			C.	D.	E.
<b>SECTION A - DIRECT PROPERTY EXP.</b>					
1. Property insurance (s31)	\$ 4,695				
2. Mortgage insurance (s31)	-				
3. Amortization debt premium discount (s32)	94,535				
4. Plant asset interest expense (s33)	263,485				
5. Depreciation land improvements (s34)	2,981				
6. Depreciation buildings (s34)	151,996				
7. Depreciation leasehold improve. (s34)	-				
8. Depreciation fixed equipment (s34)	-				
9. Depreciation moveable equip. (s34)	40,666				
10. Depreciation transportation veh. (s34)	-				
11. Depreciation other (s34)	-				
12. Expense on operating leases (s35)	16,472				
13. Expense on capitalized leases (s36)	-				
14. Property taxes or fees (s37)	-				
15. TOTAL EXPENSE (sum 1-14)	\$ 574,830	\$ -			
16. Less total directly assigned property exp.	\$ -	(sum 15B, 15C 15D, 15E)			
17. NET UNASSIGNED/INDIRECT PROP. . . . .	\$ 574,830	(15A less 16A)			
<b>SECTION B - NON-SALARY EXPENSES</b>					
18. Square feet of service's building area	20,020	20,020			
19. Ratio to total square feet to 4 decimals	1.0000	1.0000			
20. Indirect property expense allocation	\$ 574,830 (from 17A)	574,830 20A X 19B	- 20A X 19C	- 20A X 19D	- 20A X 19E
<b>SECTION C - TOTAL</b>					
21. TOTAL PROP. EXP. FOR EACH AREA	\$ 574,830 17A + 20 A	\$ 574,830 15B + 20B	\$ - 15C + 20C	\$ - 15D + 20D	\$ - 15E + 20E

**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.  Accrual  Cash
2. Capitalization of plant assets - briefly describe the facility's policy or practice for the capitalization of plant assets purchases. The equipment has an estimated useful life of at least 2 years and an acquisition cost of \$1,000.

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3. Volunteer and unpaid employees - briefly explain if and how volunteer and other unpaid employee hours are reported in this cost report

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4. Conformity - describe any accounting practices/policies in reporting revenues and expenses which are known to NOT conform to generally accepted accounting principles.

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

**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					G. Expense Incurred by Related Party	H. Difference (G - F)
	B. Cost Ctr.	C. Schedule	D. Column	E. Line	F. Expense		
1. Total related party lease expense					( )	XXXXXXXXXX	XXXXXXXXXX
2. Insurance expense					XXXXXXXXXX		XXXXXXXXXX
3. Amortization deferred expense					XXXXXXXXXX		XXXXXXXXXX
4. Interest expense					XXXXXXXXXX		XXXXXXXXXX
5. Depreciation expense					XXXXXXXXXX		XXXXXXXXXX
6. Property tax expense					XXXXXXXXXX		XXXXXXXXXX
7. _____					XXXXXXXXXX		XXXXXXXXXX
8. _____					XXXXXXXXXX		XXXXXXXXXX
9. SUBTOTAL FOR RELATED PARTY LEASES					( \$ - )	\$ -	\$ -

**SECTION B - OTHER RELATED PARTY TRANSACTIONS**

10. Home Office Costs	Sdmin	26 ATT	1	1	( \$ 37,280 )	\$ 27,559	\$ (9,721)
11. _____					( )		-
12. _____					( )		-
13. _____					( )		-
14. _____					( )		-
15. TOTAL AMOUNT TO ADJUST RELATED PARTY TRANSACTIONS TO COST (to schedule 11, line 18)							<b>(9,721)</b>

**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.

Wisconsin Illinois Senior Housing (WISH) Lakewood, CO

**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.

A. Description of Expense Item	Amount	Location of Expense in Cost Report			
		Cost Ctr.	Schedule	Column	Line
1. Promotional expenses	\$ 2,654	Admin	26 ATT	1	6
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	34,076	Admin	26 ATT	1	2
8. Interest expense on non-care working capital loans					
9. Interest expense on non-care plant asset loans					
10. Non-care related membership fees					
11. Training programs for non-employees					
12. Special legal and professional fees (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 Abandoned Planning Expenses					
21 Other - describe: <u>Occupied Bed Tax</u>	102,000	Admin	26	1	9
22 Other - describe: _____					

### 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. <u>General Business Matters</u>	<u>5,978</u>
15. _____	
16. <b>TOTAL LEGAL FEES (should equal schedule 26, line 8).</b> .....	<b>\$ 5,978</b>

**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.

**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.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								

**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.	Wisconsin Illinois Senior Housing (WISH)	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.	See Attached.		
2.			
3.			
4.			
5.			



### SCHEDULE 51 - MEDICAL SUPPLY REVENUES FROM MEDICARE PART B

**INSTRUCTIONS:** Wisconsin Medicaid policies and statutory authority on Medicare maximization include nursing homes billing Medicare for medical supplies and equipment under Medicare Part B. All Medicare-certified nursing homes should be billing Medicare Part B for services and supplies covered by the Medicare program. Nursing homes that are not Medicare certified may bill Medicare under Part B for medical supplies if they have separate Medicare certification as a durable medical equipment and supply vendor. Nursing home revenues from Medicare Part B should be included in the medical supply revenue on schedule 14 and must be identified on this schedule to properly account for third party payer revenues.

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1. Does the nursing home bill Medicare for covered medical supplies under Medicaid Part B for Medicare eligible residents?.....  Yes  No

2. Is the nursing home Medicare certified?.....  Yes  No  
If yes, submit a copy of worksheet D from the most recent Medicare Cost Report.

3. Does the nursing home have a separate Medicare certification to bill for equipment and supplies?.....  Yes  No

4. Medical supplies are billed to Medicare for the following types of residents (check all that apply) . . . . .  Private Pay  Title XIX (Medicaid)  Other

5. What were the Medicare Part B revenues for medical supplies? . . . . . \_\_\_\_\_

6. What were the costs related to the above medical supply revenues and where were they reported on this cost report?  
a. Expense \_\_\_\_\_ schedule \_\_\_\_\_ column \_\_\_\_\_ line \_\_\_\_\_  
b. Expense \_\_\_\_\_ schedule \_\_\_\_\_ column \_\_\_\_\_ line \_\_\_\_\_

**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 from 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	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. <b>TOTAL MISCELLANEOUS MEDICAID NON-RATE REVENUES (sum 1-7) .....</b>	<b>\$ -</b>		

### 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 single 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

YES, my facility is requesting a private room incentive. If YES specify one and continue:  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, 2018, to qualify for one of the private room incentives.

#### AFFIDAVIT

I HEREBY ATTEST and affirm that from July 1, 2019, to June 30, 2020, the East Troy Manor 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, 2019, if the facility has charged Medicaid residents for private rooms during this period.

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

#### PROPERTY INCENTIVE:

Did the facility get approval for innovative property incentive on or after 7/1/12? See Sec. 3.655 of Methods of Implementation  YES  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  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"? \_\_\_\_\_