

WISCONSIN MEDICAID PROGRAM 2020 NURSING HOME COST REPORT

SCHEDULE 1: Facility & Preparer Information

SECTION A - FACILITY INFORMATION

Facility Name Hales Corners Care Center		Main Telephone Number 414-529-6888	Main Email Address administrator@halescornerscarecenter.c	
Facility Street Address 9449 West Forest Home Avenue		City Hales Corners	State WI	Zip Code 53130
Contact Person Cindy Berg		Contact Telephone Number 262-953-2815	Contact Email Address administrator@halescornerscarecenter.com	
Cost Report Period Start Date 1/1/2020	Cost Report Period End Date 12/31/2020	Medicaid Provider Number 20176900	National Provider Identifier (NPI) 1003813569	POP ID Number 401
Administrator Cindy Berg	Chief Financial Officer none	Where are the financial records of the nursing home located? At the facility		

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

Name and Title Wipfli LLP		Telephone Number 414-431-9335		
Address 10000 Innovation Drive, Sutie 250		City Milwaukee	State WI	Zip Code 53226
SIGNATURE - Original Signature of Preparer			Date Signed	

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

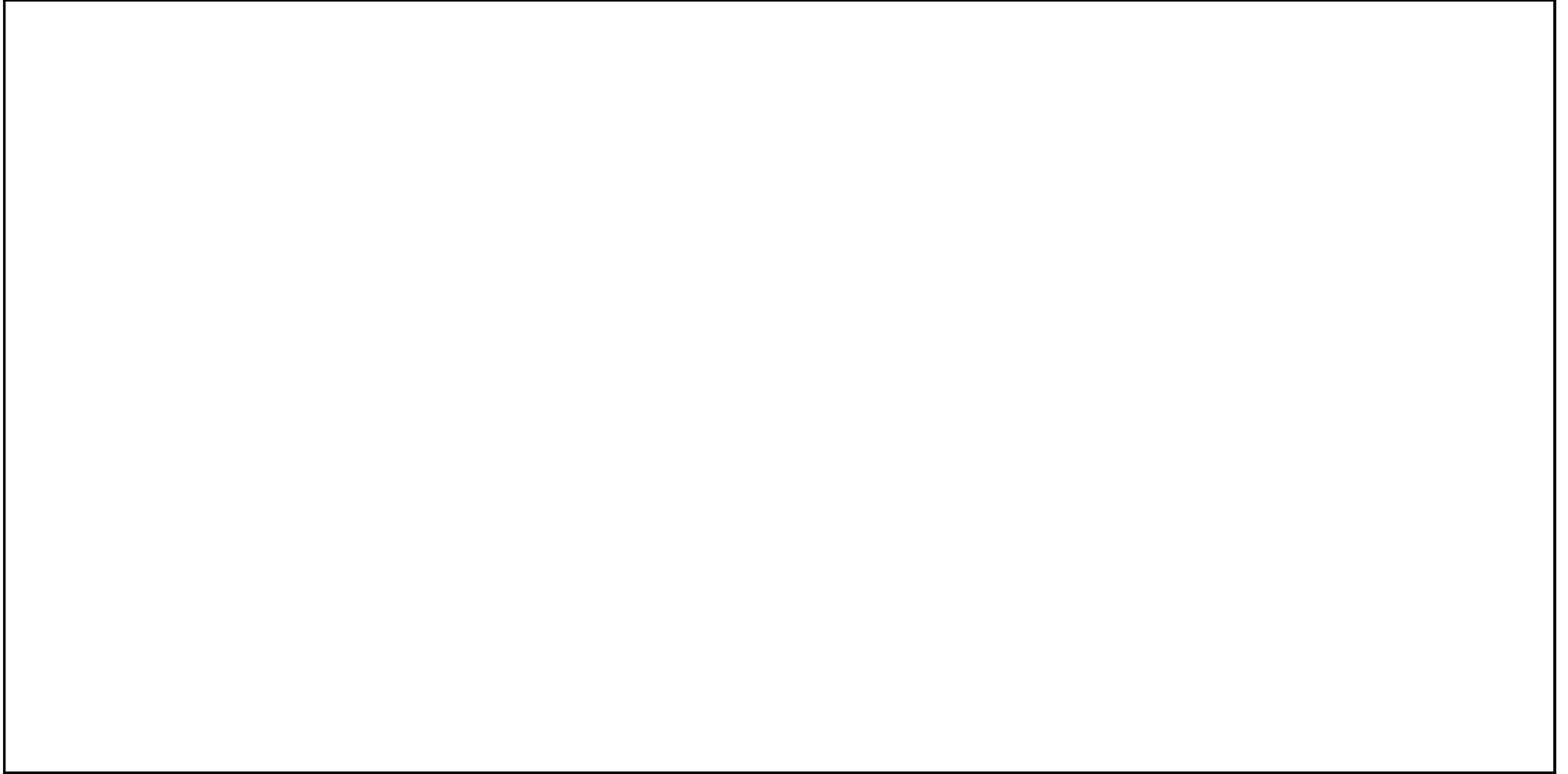
This certification must be signed and submitted before the information included in the cost report can be used to calculate Medicaid payment rates. Misrepresentation or falsification of any information contained in this report may be punishable by fine and/or imprisonment under state or federal law.

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

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

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

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

SCHEDULE 3: General Information

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

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

3. County of facility Milwaukee County Code 40

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

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

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

	DATE	BEDS
<u>Beds at Beginning of Cost Reporting Period</u>	<u>1/1/2020</u>	<u>62</u>
If there has been a change in the number of licensed beds, list the date(s) of the change(s), the number of beds and briefly explain.	<u>12/31/2020</u>	<u>62</u>

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

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

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

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

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

	A. NAME	B. License Number	C. Single-Bed Rooms	D. Beds in Multiple-Bed Rooms	E. Total Licensed Beds
1.	<u>Hales Corners Care Center</u>	<u>3172</u>	<u>44</u>	<u>18</u>	<u>62</u>
2.					-
3.					-
4.	TOTAL		<u>44</u>	<u>18</u>	<u>62</u>

SCHEDULE 4: Shared Services

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

SCHEDULE 5 - NO LONGER USED

SCHEDULE 6: Total Patient Days

	LEVEL OF CARE (LOC)		
	NON DD	DD	TOTAL
1a. Medicaid (T-19)	2,229		2,229
1b. ICF-IID Medicaid (T-19)			-
1c. Family Care (T-19)			-
1d. Other Medicaid Managed Care (T-19)			-
1e. Hospice (T-19)	457		457
1f. Ventilator (T-19)			-
2a. Medicare (T-18)	3,607		3,607
2b. Medicare Advantage, for days covered as a Part A stay	1,041		1,041
3a. Private pay & Insurance	7,307		7,307
3b. Medicare Advantage, for days not covered as a Part A stay			-
3c. Hospice (Private pay & Insurance)	217		217
4. Other, Specify: _____			
5. TOTAL INHOUSE PATIENT DAYS.	14,858	-	14,858

SECTION B - BED HOLD DAYS			
Charged Bed Hold Days Only			
	NON DD	DD	TOTAL
6a. Medicaid (T-19)	19		19
6b. ICF-IID Medicaid (T-19)			-
6c. Family Care & Partnership (T-19)			-
7. All Other	95		95
8. TOTAL CHARGED BED HOLD DAYS.	114	-	114

SECTION C - TOTAL PATIENT DAYS			
	NON DD	DD	TOTAL
9. TOTAL DAYS	14,972	-	14,972

SCHEDULE 7 - NO LONGER USED

SCHEDULE 8: Medicaid Bedhold Eligibility

1. MONTH	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
2. Days in Month	31	29	31	30	31	30	31	31	30	31	30	31	366
3. Licensed Beds for Bed Hold Testing	62	62	62	62	62	62	62	62	62	62	62	62	744
4. Occupancy Test: Row 2 x (Row 3 x 94%)	1,807	1,690	1,807	1,748	1,807	1,748	1,807	1,807	1,748	1,807	1,748	1,807	21,331
5. Inhouse patient days	1,786	1,564	1,621	1,320	985	783	1,023	1,108	1,023	1,164	1,202	1,279	14,858
6. Bed Hold days	2	19	47	5	-	6	2	12	4	12	-	5	114
7. TOTAL DAYS	1,788	1,583	1,668	1,325	985	789	1,025	1,120	1,027	1,176	1,202	1,284	14,972
	n/a	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	

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

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

SCHEDULE 9 - NO LONGER USED

SCHEDULE 10: Balance Sheet

ASSETS			LIABILITIES AND OWNERS' EQUITY				
	Begin Date 1/1/20	End Date 12/31/20		Begin Date 1/1/20	End Date 12/31/20		
CURRENT ASSETS	Cash on hand and in bank	\$670,429	\$1,358,809	CURRENT LIABILITIES	Notes and loans payable, list below:		
	Temporary investments				Note Payable M&I - LT	\$-	\$1,001,375
	Resident accounts receivable	547,252	474,913				
	Other accounts receivable						
	Due from related parties	885,762	972,106				
	Notes receivable				Due to related parties		
	Accrued interest receivable				Accounts payable	93,157	144,657
	Inventories	15,010	11,351		Accrued salaries	443,811	447,116
	Prepaid expenses	14,925	204,283		Other accrued expenses		
	Resident funds held in trust				Resident trust funds payable	84	96
Other current assets, list below:			Other current liabilities				
			TOTAL CURRENT LIABILITIES	\$537,052	\$1,593,244		
TOTAL CURRENT ASSETS	\$2,133,378	\$3,021,462					
PROPERTY, PLANT, EQUIP.	Land			LONG TERM LIAB.	Notes and loans payable (list) below:		
	Land improvements	34,360	34,360				
	Buildings				Other long term liabilities		
	Leasehold improvements	264,520	264,520		TOTAL LONG TERM LIABILITIES	\$-	\$-
	Fixed equipment						
	Moveable equipment	255,260	274,291				
	Transportation equipment						
	Other						
Less: accumulated depreciation	(411,593)	(433,400)					
TOTAL PROPERTY, PLANT, EQUIPMENT	\$142,547	\$139,771					
OTHER	Long term investments			OWNER EQUITY	OWNERS' EQUITY, list below:		
	Other Assets, list below:				Retained Earnings	1,098,405	1,749,672
	Bed License - Net of Amort.	10,800	10,080		Net Income	651,268	(171,603)
					TOTAL OWNER'S EQUITY	\$1,749,673	\$1,578,069
TOTAL OTHER ASSETS	\$10,800	\$10,080					
TOTAL ASSETS	\$2,286,725	\$3,171,313	TOTAL LIABILITIES AND EQUITY	\$2,286,725	\$3,171,313		

SCHEDULE 10A: Summary of Changes to Equity

1.	Beginning Owners' Equity (from schedule 10)		\$1,749,673
2. Add	Net income (from schedule 11, line 19)	\$-	
	Owners' capital contribution		
	County appropriation		
	Net decrease in accrued vacation, holiday and sick time		
	Other, Specify: <u>Other Adjustment</u>	1,033	
	Other, Specify: _____		
	Total additions		1,033
3. Deduct	Net loss (from schedule 11, line 19)	(\$165,780)	
	Dividends and withdrawals	()	
	Net increase in accrued vacation, holiday and sick time	(2,179)	
	Other, Specify: <u>Depreciation Adjustment</u>	(4,678)	
	Other, Specify: _____	()	
	Total deductions		(172,637)
4. ENDING OWNERS' EQUITY (schedule 10)			\$1,578,069

SCHEDULE 11: Summary of Revenues & Expenses

All values are automatically posted from other schedules.

SECTION A - SUMMARY OF REVENUE

1. Daily patient service revenue	schedule 14, lines 1-4	\$ 5,480,181
2. Service fees	schedule 15, line 14A	1,016,596
3. Rent from outside medical providers	schedule 15, line 14B	-
4. Other	schedule 15, line 14C	-
5. Dietary revenues	schedule 16, line 5A	-
6. Miscellaneous services and materials revenue	schedule 16, line 16	10,176
7. Rental revenues	schedule 17, line 22	397
8. Revenues from other major activities	schedule 17, line 38	-
9. Sales to related organizations	schedule 18, line 41	-
10. Investment revenue	schedule 18, line 42	(120)
11. Gains (Losses) on disposal of assets	schedule 18, line 43	-
12. Grants for government-subsidized employees	schedule 18, line 44	-
13. Grants, contributions, donations	schedule 18, line 45	-
14. Other revenue	schedule 18, line 50	634,887
15. Subtract: deductions from revenues	schedule 14, line 5	(469,175)
16. NET REVENUES		\$ 6,672,942

SECTION B - SUMMARY OF NET INCOME OR LOSS

17. Subtract: total expenses	schedule 12, line 37	\$ (6,953,317)
18. Add or subtract the amount to adjust related party transactions to cost	schedule 42, line 15	114,595
19. NET INCOME OR LOSS		\$ (165,780)

SCHEDULE 12: Summary of Total Expenses

All values are automatically posted from other schedules.

Cost Center	Reference	Expense	Cost Center	Reference	Expense
1. Daily patient service expense	S20, L10	<u>\$2,358,609</u>	20. Transportation	S25, L14f	<u>\$-</u>
2. Laboratory & Radiology	S21, L13a	<u>32,110</u>	21. Administrative service expense	S26, L12	<u>883,811</u>
3. Respiratory	S21, L13b	<u>-</u>	Other cost centers, Specify:		
4. Pharmacy	S21, L13c	<u>135,410</u>	22. <u>Nurse Aide Training</u>	S27, L16a	
5. PT, OT and Speech	S22, L13a	<u>649,569</u>	23. <u>Beauty/Barber Shop</u>	S27, L16b	
6. Dental	S22, L13b	<u>-</u>	24. <u>0</u>	S27, L16c	
7. Physician	S22, L13c	<u>12,000</u>	25. <u>0</u>	S27, L16d	
8. Social Services	S23, L13a	<u>115,513</u>	26. <u>0</u>	S27, L16e	
9. Recreational Activities	S23, L13b	<u>110,632</u>	UNASSIGNED EXPENSES		
10. Religious Services	S23, L13c	<u>-</u>	27. Employee fringe benefit expense	S28, L17	<u>1,045,756</u>
11. Volunteer Coordinator	S24, L13a	<u>-</u>	28. Heating fuel and utility expense	S29, L10	<u>109,053</u>
12. Ward Clerks	S24, L13b	<u>29,005</u>	29. Interest on operating working capital loans .	S30, L6	<u>-</u>
13. Psychotherapy	S24, L13c	<u>250</u>	30. Insurance expense	S31, L9	<u>2,635</u>
14. Other	S24, L13d	<u>-</u>	31. Amortization expense	S32, L5	<u>720</u>
15. Dietary	S25, L14a	<u>506,368</u>	32. Interest on plant asset loans	S33, L15h	<u>-</u>
16. Plant Operations and Maintenance	S25, L14b	<u>145,647</u>	33. Depreciation expense	S34, L20c	<u>17,129</u>
17. Housekeeping	S25, L14c	<u>181,447</u>	34. Expense on operating and non-cap.leases	S35, L14	<u>537,529</u>
18. Laundry and Linen	S25, L14d	<u>79,385</u>	35. Expense on capitalized leases	S36A, L5	<u>-</u>
19. Security	S25, L14e	<u>-</u>	36. Property tax expense	S37, L7	<u>739</u>
			37. TOTAL EXPENSES FOR REPORT PERIOD		<u>\$6,953,317</u>
			(To schedule 11, line 17)		

SCHEDULE 13: Summary of Salary & Wage Expenses

All values are automatically posted from other schedules.

Cost Center and Schedule	Total Salary and Wage Expense	Cost Center and Schedule	Total Salary and Wage Expense
Daily patient service S20, L1d	\$1,952,160	Dietary S25, L1a	305,034
Laboratory & Radiology S21, L1a	-	Plant operation / maintenance. S25, L1b	53,193
Respiratory S21, L1b & 3b	-	Housekeeping S25, L1c	157,853
Pharmacy S21, L1c & 3c	-	Laundry and Linen S25, L1d	61,824
PT, OT and Speech S22, L1a & 3a	633,143	Security S25, L1e	-
Dental S22, L1b & 3b	-	Transportation S25, L1f	-
Physician S22, L1c & 3c	-	Administrative service S26, L5	623,104
Social Services S23, L3a	115,309	Nurse aide training S27, L1a	-
Recreational Activities S23, L3b	99,942	Beauty and barber S27, L1b	-
Religious Services S23, L3c	-	Other, Specify: 0 S27, L1c	-
Volunteer Coordinator S24, L3a	-	0 S27, L1d	-
Ward Clerks S24, L3b	29,005	0 S27, L1e	-
Psychotherapy S24, L1c & 3c	-	TOTAL SALARY AND WAGE EXPENSE.	\$4,030,567
Other S24, L1d & 3d	-		

SCHEDULE 14: Daily Patient Service Revenues

SECTION A - DAILY RATE CHARGES

	Revenue
1. Medicare Daily Rate	\$1,349,240
2. Medicaid Daily Rate (including bed hold)	843,200
3. Private Pay	2,866,173
4. Medical Supplies, Other	421,568

SECTION B - Deductions From Revenue

5. TOTAL DEDUCTIONS FROM REVENUE (469,175)

SECTION C - TOTAL

6. TOTAL DAILY PATIENT SERVICE REVENUE \$5,011,006

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 \$300.00
 8. Facility Comment (Optional)

SCHEDULE 15: Special Services Revenue

SECTION A - SERVICE REVENUES	A. Service Fee Charges	B. Rent from Outside Medical Providers	C. From Other Sources	Describe Other
1. Laboratory	\$35,209			
2. Radiology	11,784			
3. Pharmacy	143,050			
4. Physical therapy	332,942			
5. Speech/hearing therapy	64,039			
6. Occupational therapy	410,285			
7. Physician care				
8. Psychotherapy				
9. Respiratory therapy	19,287			
10. Social services				
11. Recreational activities				
12. Special duty nursing				
13. Other, Specify: _____				
14. TOTAL SPECIAL SERVICE REVENUE ..	\$1,016,596	\$-	\$-	

SECTION B - THERAPY REVENUES

15. Are physical, occupational, or speech therapy services provided by staff, assistants, contractors, or consultants IN SPACE AT YOUR FACILITY?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
16. Total gross billings for physical, occupational, and speech therapy services provided at your facility during the cost report period Provide the total regardless of who provides the services, who bills for the services, or who receives the services (residents vs. non-residents).			<u>\$807,266</u>
17. From section A, total the amounts in columns A, B and C on lines 4, 5 and 6 (sum 4A, 4B, 4C, 5A, 5B, 5C, 6A, 6B, 6C)			<u>\$807,266</u>
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?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, amount of revenue <u>\$578</u>
20. Does your facility or related organization bill Medicare Part B for therapy services at your facility?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, amount of revenue <u>\$33,175</u>
21. Did you charge rent to a rehabilitation agency or independent contractor?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, amount of revenue _____

SCHEDULE 16: Other Revenues

SECTION A - CAFETERIA AND DIETARY REVENUE

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

SECTION B - MISCELLANEOUS SERVICES AND MATERIALS

		<u>Expenses Directly Ascribable To Or Identifiable With Revenue</u>			
	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	23	_____	_____	_____
10.	Gift Shop	_____	_____	_____	_____
11.	Canteen and snack counter	_____	_____	_____	_____
12.	Vending machines	3,133	_____	_____	_____
13.	Sale of clothing	_____	_____	_____	_____
14.	Television and cable service	_____	_____	_____	_____
15.	Telephone and Internet	7,020	_____	_____	_____
16.	TOTAL MISCELLANEOUS SERVICES AND MATERIALS	_____ \$10,176			

SCHEDULE 17: Other Revenues

SECTION A - RENTAL REVENUE				
	<u>Revenue</u>	<u>Property Rented</u>	<u>Square Feet Rented</u>	<u>Services Provided</u>
18. Equipment rental	\$397			
19. Rental of nursing home space				
20. Rental of non-nursing home space				
21. Parking				
22. TOTAL RENTAL REVENUES	\$397			

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

SCHEDULE 18: Other Revenues

		Revenue
	SALES TO RELATED ORGANIZATIONS	
38.	_____	_____
39.	_____	_____
40.	_____	_____
41.	TOTAL SALES TO RELATED ORGANIZATIONS	\$-
42.	TOTAL INVESTMENT REVENUE	\$(120)
43.	TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS	_____
44.	TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES	_____
45.	TOTAL GRANTS, CONTRIBUTIONS, DONATIONS	_____
	OTHER REVENUES	
46.	Other revenue	\$6,566
47.	Non-Nursing home revenues	628,321
48.	_____	_____
49.	_____	_____
50.	TOTAL OTHER REVENUES	\$634,887

SCHEDULE 20: Daily Patient Service Expense

<u>Salaries, Wages & Purchased Serv.</u>	<u>A. Registered Nurses</u>	<u>B. Licensed Practical Nurses</u>	<u>C. Nurse Aides and Assistants</u>	<u>D. Total Expense or Hours</u>
1. TOTAL SALARY AND WAGE EXPENSE	\$588,422	\$517,001	\$846,737	\$1,952,160
2. TOTAL SALARY AND WAGE HOURS	15,749 hrs.	16,723 hrs.	49,323 hrs.	\$81,795
3. EXPENSE FOR PURCHASED SERVICES	\$109,377	\$19,735	\$-	\$129,112
AVERAGE WAGE PER HOUR	\$37.36	\$30.92	\$17.17	\$23.87
NURSING AND INCONTINENCY SUPPLIES				
4. Catheters, Incontinency Supplies (including purchased laundry service)				_____
OXYGEN				
5. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental				15,783
OTHER				
6. Other medical supplies, personal comfort supplies and minor medical equipment				91,506
7. Nonbillable over the counter (OTC) drugs for all residents (include billable OTC drugs on Schedule 21, Line 9c)				15,028
8. Other nursing				155,020
9. _____				_____
10. TOTAL DAILY PATIENT SERVICE EXPENSE				\$2,358,609

SCHEDULE 21: Special Service Expenses

	TYPE OF SERVICE		
	<u>A. Laboratory & Radiology</u>	<u>B. Respiratory</u>	<u>C. Pharmacy</u>
SECTION A - SALARY AND WAGES			
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	\$-	\$-	\$-
<hr/>			
SECTION B - PURCHASED SERVICES			
6. Expense for purchased service - Billable	\$32,110		
7. Expense for purchased service - Non billable	\$-		\$2,061
<hr/>			
SECTION C - SUPPLY AND OTHER EXPENSE			
8. Pharmacy - legend drugs Billable	\$-	\$-	133,349
9. Pharmacy - over the counter drugs Billable	\$-	\$-	
10. Supply and Other			
11. _____			
12. _____			
<hr/>			
SECTION D - TOTAL			
13. TOTAL EXPENSES	\$32,110	\$-	\$135,410
14. TOTAL HOURS	hrs.	hrs.	hrs.

SCHEDULE 22: Special Service Expenses

	TYPE OF SERVICE		
	A. Physical, Occupational And Speech Therapy	B. Dental	C. Physician
SECTION A - SALARY AND WAGES			
1. Expense for hours worked - Billable.....	\$633,143		
2. Number of hours worked - Billable.....	18,878 hrs.		
3. Expense for hours worked - Non-billable.....			
4. Number of hours worked - Non-billable.....			
5. TOTAL SALARY AND WAGE EXPENSE	\$633,143	\$-	\$-
SECTION B - PURCHASED SERVICES			
6. Expense for purchased service - Billable.....	\$4,490		
7. Expense for purchased service - Non billable.....			\$12,000
SECTION C - SUPPLY AND OTHER EXPENSE			
8. therapy supplies	11,936		
9. _____			
10. _____			
11. _____			
12. _____			
SECTION D - TOTAL			
13. TOTAL EXPENSES.....	\$649,569	\$-	\$12,000
14. TOTAL HOURS.....	18,878 hrs.	hrs.	hrs.

SCHEDULE 23: Special Service Expenses

	TYPE OF SERVICE		
	A. Social Services	B. Recreational Activities	C. Religious Services
SECTION A - SALARY AND WAGES			
1. Expense for hours worked - Billable	\$-	\$-	\$-
2. Number of hours worked - Billable	hrs.	hrs.	hrs.
3. Expense for hours worked - Non-billable	\$115,309	\$99,942	
4. Number of hours worked - Non-billable	4,223 hrs.	5,276 hrs.	
5. TOTAL SALARY AND WAGE EXPENSE	\$115,309	\$99,942	\$-
SECTION B - PURCHASED SERVICES			
6. Expense for purchased service - Billable	\$-	\$-	\$-
7. Expense for purchased service - Non billable		\$4,438	
SECTION C - SUPPLY AND OTHER EXPENSE			
8. <u>supplies and other</u>	\$204	\$6,252	
9. _____			
10. _____			
11. _____			
12. _____			
SECTION D - TOTAL			
13. TOTAL EXPENSES	\$115,513	\$110,632	\$-
14. TOTAL HOURS	4,223 hrs.	5,276 hrs.	hrs.

SCHEDULE 24: Special Service Expenses

	TYPE OF SERVICE			
	A. Volunteer Coord.	B. Ward Clerks	C. Psychotherapy	
SECTION A - SALARY AND WAGES				
1. Expense for hours worked - Billable	\$-	\$-		
2. Number of hours worked - Billable	hrs.	hrs.		
3. Expense for hours worked - Non-billable		\$29,005		
4. Number of hours worked - Non-billable		1,598 hrs.		
5. TOTAL SALARY AND WAGE EXPENSE	\$-	\$29,005	\$-	\$-
SECTION B - PURCHASED SERVICES				
6. Expense for purchased service - Billable			\$250	
7. Expense for purchased service - Non billable				
SECTION C - SUPPLY AND OTHER EXPENSE				
8. _____				
9. _____				
10. _____				
11. _____				
12. _____				
SECTION D - TOTAL				
13. TOTAL EXPENSES	\$-	\$29,005	\$250	
14. TOTAL HOURS	hrs.	1,598 hrs.	hrs.	hrs.

SCHEDULE 25: General Service Expenses

SECTION A - SALARIES AND WAGES	A. Dietary	B. Plant Op./Maint.	C. Housekeeping	D. Laundry / Linen	E. Security	F. Transportation
1. TOTAL SALARY AND WAGE EXPENSE	\$305,034	\$53,193	\$157,853	\$61,824		
2. NUMBER OF HOURS WORKED	19,917 hrs.	2,613 hrs.	11,215 hrs.	5,488 hrs.		
SECTION B - DIETICIAN CONSULTANT						
3. Dietician consultant expense		\$-	\$-	\$-	\$-	\$-
SECTION C - OUTSIDE SERVICE						
4. Contracted services	\$10,705	\$46,992				
5. _____						
6. _____						
7. _____						
8. TOTAL OUTSIDE SERVICE EXPENSES	\$10,705	\$46,992	\$-	\$-	\$-	\$-
SECTION D - SUPPLY AND OTHER EXPENSE						
9. supplies and other	\$190,629	\$45,462	\$23,594	\$17,561		
10. _____						
11. _____						
12. _____						
13. _____						
SECTION E - TOTAL						
14. TOTAL EXPENSES	\$506,368	\$145,647	\$181,447	\$79,385	\$-	\$-

SCHEDULE 25A: Support Services Expense Allocations

SECTION A - ALLOCATION OF DIETARY EXPENSES

1. Total dietary expenses (from Schedule 25, Line 14a)	<u>\$506,368</u>
2. Deduct expense for food products provided to employees without charge (to line 9 below)	
3. Deduct amount for donated and surplus food commodities included in dietary expense (from schedule 16, line 1)	<u>\$-</u>
4. Deduct revenue (related expense) for food products sold (from schedule 16, line 2)	<u>\$-</u>
5. NET DIETARY EXPENSES TO ALLOCATE (to line 8 A below)	<u>\$506,368</u>

	A. Total	B. Residents'	C. Employees'	D. Meals on	E. Other	F. Other
		Meals	Meals	Wheels		
6. Meals served	<u>43,830</u>	<u>43,830</u>				
7. Ratio to total meals served to 4 decimals	<u>1.0000</u>	<u>1.0000</u>				
8. DIETARY EXPENSE ALLOCATION (see instructions below line to complete)	<u>\$506,368</u> <small>From line 5</small>	<u>\$506,368</u> <small>8A x 7B</small>	<u>\$-</u> <small>8A x 7C</small>	<u>\$-</u> <small>8A x 7D</small>	<u>\$-</u> <small>8A x 7E</small>	<u>\$-</u> <small>8A x 7F</small>
9. Food products provided to employees without charge (from line 2)			<u>\$-</u>			
10. Deduct revenue from meals sold to employees (from schedule 16, line 3)			<u>-</u>			
11. NET EXPENSE (PROFIT) FOR MEALS AND FOOD PROVIDED TO EMPLOYEES (line 8C + line 9C - line 10C)			<u>\$-</u>			

SECTION B - ALLOCATION OF PLANT OPERATION AND MAINTENANCE EXPENSES

	A. Total	B. Nursing Home	C. Emp. Unique	Non-Nursing Home Areas w/ Plant Operation and Maint.		
	Area	Area	Fringe Benefit Area	D.	E.	F.
12. Total square feet for areas	<u>42,452</u>	<u>42,452</u>				
13. Ratio to total square feet to 4 decimals . .	<u>1.0000</u>	<u>1.0000</u>				
14. TOTAL PATIENT OP/MAINT EXP. ALLOC. <small>From S25, L18</small>	<u>\$145,647</u> <small>From S25, L18</small>	<u>\$145,647</u> <small>14A x 13B</small>	<u>\$-</u> <small>14A x 13C</small>	<u>\$-</u> <small>14A x 13D</small>	<u>\$-</u> <small>14A x 13E</small>	<u>\$-</u> <small>14A x 13F</small>

SCHEDULE 25B: Support Services Expense Allocations

SECTION A - ALLOCATION OF HOUSEKEEPING EXPENSES

Non-Nursing Home Areas Receiving Housekeeping Services

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			
15. Square feet or hours of service provided	<u>42,452</u>	<u>42,452</u>			
16. Ratio to total sq. ft./hours to 4 decimals	<u>1.0000</u>	<u>1.0000</u>			
17. TOTAL HOUSEKEEPING EXP. ALLOC.	<u>\$181,447</u>	<u>\$181,447</u>	<u>\$-</u>	<u>\$-</u>	<u>\$-</u>
	From S25, L18	17A x 16B	17A x 16C	17A x 16D	17A x 16E

SECTION B - ALLOCATION OF LAUNDRY AND LINEN EXPENSES

Non-Nursing Home Areas Receiving Laundry/Linen Services

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			
18. Pounds of laundry processed	<u>1</u>	<u>1</u>			
19. Ratio to total pounds to 4 decimals	<u>1.0000</u>	<u>1.0000</u>			
20. TOTAL LAUNDRY/LINEN EXP. ALLOC.	<u>\$79,385</u>	<u>\$79,385</u>	<u>\$-</u>	<u>\$-</u>	<u>\$-</u>
	From S25, L18	20A x 19B	20A x 19C	20A x 19D	20A x 19E

SECTION C - ALLOCATION OF SECURITY EXPENSES

Non-Nursing Home Areas Receiving Security Services

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

SECTION D - ALLOCATION OF TRANSPORTATION EXPENSES

Non-Nursing Home Areas Receiving Transportation Services

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

SCHEDULE 26: Administrative Service Expenses

		Expenses
SECTION A - SALARY AND WAGES		
1.	General Admin & Accounting	\$244,312
2.	Medical Records	24,261
3.	Central Supply	194,642
4.	Scheduling	159,889
5.	Total Salary and Wage Expense	\$623,104
SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS		
6.	Home office costs allocated to facility	
	Name of home office _____	
	From (date) _____	
	Through (date) _____	
7.	County costs allocated to facility	
SECTION C - NON-SALARY EXPENSES		
8.	Purchased services - legal	\$9,993
9.	Licensed bed assessment	
10.	Contractual management fees	
11.	Total other non-salary (from schedule 26 attachment)	250,714
SECTION D - TOTAL		
12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES	\$883,811

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

Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1. advertising	\$3,196
2. Supplies	14,262
3. professional fees	69,203
4. bank fees	3,701
5. copiers	11,395
6. postage	4,457
7. computer	64,528
8. telephone	12,112
9. bad debts	17,810
10. travel	322
11. Penalties & Fines	7,296
12. other admin	42,432
13. _____	_____
14. _____	_____
15. _____	_____
16. TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11)	\$250,714

SCHEDULE 26: Related Party Administrative Service Expenses

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

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

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

SCHEDULE 26B: Allocation of Administrative Expenses

1. Total Admin. Service Expense (S26, 12) \$883,811

SECTION A - DIRECT EXPENSES

Non-Nursing Home Areas Receiving Administrative Services

Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider			
2. all admin	<u>\$(883,811)</u>	<u>\$883,811</u>			
3.	-				
4.	-				
5.	-				
6.	-				
7.	-				
8.	-				
9.	-				
10.	-				
11.	-				
12.	-				
13.	-				
14.	-				
15. TOTAL DIRECT EXPENSE.....	<u>\$(883,811)</u>	<u>\$883,811</u>			
16. NET UNASSIGNED EXPENSE	<u>\$-</u>				

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	<u>\$883,811</u>	<u>\$883,811</u>	<u>\$-</u>	<u>\$-</u>	<u>\$-</u>
	(line 15A + 19A)	B15 + B19	C15 + C19	D15 + D19	E15 + E19

SCHEDULE 27: Other Cost Centers

SECTION A - SALARY AND WAGES

	<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
1. TOTAL SALARY AND WAGE EXPENSE	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
2. NUMBER OF HOURS WORKED	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>

SECTION B - NON-SALARY EXPENSES

	<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>	<u>-</u>	<u>-</u>	<u>-</u>
3. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
4. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
5. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
6. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
7. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
8. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
9. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
10. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
11. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
12. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
13. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
14. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
15. TOTAL NON-SALARY EXPENSES	<u>\$-</u>	<u>\$-</u>	<u>\$-</u>	<u>\$-</u>	<u>\$-</u>

SECTION C - TOTAL

	<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>	<u>-</u>	<u>-</u>	<u>-</u>
16. TOTAL EXPENSES	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>

SCHEDULE 28: Fringe Benefits

Fringe Benefits Paid on Behalf of Employees	Self-Funded?	Expense
1. Employer's share of F.I.C.A.		\$284,155
2. State unemployment compensation		5,786
3. Federal unemployemnt compensation		13,312
4. Worker's compensation insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	60,367
5. Health, Dental & Vision Insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	489,121
6. Life and disability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	2,537
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	48,702
9. Post-Employment Physicals and Vaccines		126,480
10. Uniforms		4,625
11. <u>other fringes</u>		10,671
12. _____		
13. _____		
14. _____		
15. TOTAL PAID ON BEHALF OF EMPLOYEEES		<u>\$1,045,756</u>
16. Expense for special salary or wage payments to employees not included elsewhere		
<input type="checkbox"/> Christmas bonus		
<input type="checkbox"/> Longevity bonus		
<input type="checkbox"/> Productivity bonus		
<input type="checkbox"/> Bonuses to owners and immediate family relations, Specify:		
<input type="checkbox"/> Other, Specify:		
17. TOTAL FRINGE BENEFIT EXPENSE		<u>\$1,045,756</u>

SCHEDULE 28B: Fringe Benefits - Self-Funded

Type of Self-Funded Expenses	Worker's Compensation Insurance	Health, Dental and Vision Insurance	Life and Disability Insurance	Wage Continuation Insurance	Pension and Deferred Compensation Plans
Checked as self-funded on Sch 28?					
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 and Utility Service Expenses

SECTION A - ACCRUED EXPENSE BY TYPE

	<u>Accrued Expense</u>	<u>Expense by Type</u>	<u>Accrued Expense</u>
1. Fuel oil		6. Water and sewer utility charges	20,599
2. Natural gas	12,356	7. Purchased steam	
3. L.P. gas		8. _____	
4. Coal		9. _____	
5. Electricity	76,098	10. TOTAL FUEL AND UTILITY EXPENSE . . .	\$109,053

SECTION B - ALLOCATION OF FUEL AND UTILITY EXPENSE

	<u>A. Total</u>	<u>B. NH Area</u>	<u>C. Emp. Unique Fringe Ben. Area</u>	<u>Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv.</u>		
11. Total square feet for areas	42,452	42,452				
12. Ratio to total square feet to 4 decimals	1.0000	1.0000				
13. TOTAL ALLOC. FUEL/UTIL. EXPENSE	109,053	\$109,053	\$-	\$-	\$-	\$-
	From line 10	13A x 12B	13A x 12C	13A x 12D	13A x 12E	13A x 12F

SCHEDULE 30: Working Capital Loans

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

SCHEDULE 31: Accrued Insurance Expenses

A. Type of Insurance Coverage	B. Self-Funded?	C. Insurance Expense
1. Property insurance on building and contents	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. Automobile insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Liability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	2,635
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. TOTAL INSURANCE EXPENSE		\$2,635

SCHEDULE 32: Amortized Expenses

A. Bond Issue	B. Sch. 33 Line Number	C. Original Amount	D. Number of Years Amortized	E. Unamortized Begin. Balance	F. Unamortized End. Balance	G. Amortization Expense
1. Bed License	1	\$28,800	40	\$10,800	\$10,080	\$720
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. TOTAL AMORTIZATION EXPENSE						\$720

SCHEDULE 30RP: Related Party Working Capital Loans

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

SCHEDULE 31RP: Related Party Accrued Insurance Expenses

A. Type of Insurance Coverage	B. Self-Funded?	C. Insurance Expense
1. Property insurance on building and contents	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$6,112
2. Automobile insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Liability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	37,806
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 checked="" type="checkbox"/> No	19,958
7. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9. TOTAL INSURANCE EXPENSE		\$63,876

SCHEDULE 32RP: Related Party Amortized Expenses

A. Bond Issue	B. Sch 33RP Line Number	C. Original Amount	D. Number of Years Amortized	E. Unamortized Begin. Balance	F. Unamortized End. Balance	G. Amortization Expense
1. 2015 Refinance Fees	1	\$38,993	30	\$33,887	\$32,773	\$1,114
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. TOTAL AMORTIZATION EXPENSE						\$1,114

SCHEDULE 33: Plant Asset Loans

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

SCHEDULE 33P2: Plant Asset Loans- Page 2

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

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

SCHEDULE 33RP: Related Party Plant Asset Loans

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month, Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal			G. Interest Rate	H. Interest Expense
				D. Begin date	E. 6Mo. date	F. End date		
				1/1/2020	6/30/2020	12/31/2020		
				Begin Bal.	6 Mo. Bal.	End Bal.		
1. Name <u>Oak Grove Capital</u> Related party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Purpose <u>Land and Building</u>	<u>Jul-15</u>	<u>Feb-45</u>	<u>\$4,454,598</u>	<u>\$3,945,629</u>	<u>\$3,945,629</u>	<u>\$3,945,629</u>	<u>3.63%</u>	<u>\$142,019</u>
2. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
3. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
4. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
5. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
6. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
7. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
15 TOTAL RELATED PARTY LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2).....				<u>\$3,945,629</u>	<u>\$3,945,629</u>	<u>\$3,945,629</u>		<u>\$142,019</u>

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

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

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

SCHEDULE 34: Depreciation Expenses

SECTION A - CAPITALIZED HISTORICAL COST

	Begin Date <u>1/1/2020</u>	C. Additions During Report	D. Disposals During Report	End Date <u>12/31/2020</u>
	B. Beginning Balance	Period	Period	E. Ending Balance
1. Land	-		()	\$-
2. Land Improvements	34,360		()	34,360
3. Buildings	-		()	-
4. Leasehold Improvements	264,520		()	264,520
5. Fixed equipment	-		()	-
6. Moveable equipment	47,105		()	47,105
7. Transportation vehicles	-		()	-
8. Furniture & Fixtures	153,321		()	153,321
9. Computer Equipment	54,834		()	54,834
10. TOTAL CAPITALIZED COST . .	\$554,140	\$-	(\$-)	\$554,140

SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION

	A. Depreciation	Begin Date <u>1/1/2020</u>	C. Depreciation Exp.	D. Removal of Accum.	End Date <u>12/31/2020</u>
	Method, Lives Used	B. Beginning Balance	During Report Period	Deprec. On Disposals.	E. Ending Balance
11. Land Improvements	8-15 Yr SL	\$34,360	\$-	()	\$34,360
12. Buildings		-		()	-
13. Leasehold Improvements	5-40 Yr SL	160,572	6,956	()	167,528
14. Fixed equipment		-		()	-
15. Moveable equipment	5-10 Yr SL	45,084	1,116	()	46,200
16. Transportation vehicles		-		()	-
17. Furniture & Fixtures	5-20 Yr SL	145,387	2,734	()	148,121
18. Computer Equipment	5-7 Yr SL	26,189	6,323	()	32,512
19. TOTAL ACCUMULATED DEPRECIATION		\$411,592		(\$-)	\$428,721
20. TOTAL DEPRECIATION EXPENSE			\$17,129		
21. Cost of Bariatric Equipment included with Additions reported above purchased during this cost report period					

SCHEDULE 34RP: Related Party Depreciation Expenses

SECTION A - CAPITALIZED HISTORICAL COST

	Begin Date <u>1/1/2020</u> B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period	End Date <u>12/31/2020</u> E. Ending Balance
1. Land	\$273,772		()	\$273,772
2. Land Improvements	434,628		()	434,628
3. Buildings	3,297,017		()	3,297,017
4. Leasehold Improvements	760,642		()	760,642
5. Fixed equipment	-		()	-
6. Moveable equipment	521,294		()	521,294
7. Transportation vehicles	-		()	-
8. _____			()	-
9. _____			()	-
10. TOTAL CAPITALIZED COST . .	\$5,287,353	\$-	(\$-)	\$5,287,353

SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION

	A. Depreciation Method, Lives Used	Begin Date <u>1/1/2020</u> B. Beginning Balance	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. On Disposals.	End Date <u>12/31/2020</u> E. Ending Balance
11. Land Improvements	8-20 Yr SL	\$432,044	\$1,311	()	\$433,355
12. Buildings	40 Yr SL	1,963,749	81,341	()	2,045,090
13. Leasehold Improvements	5-10 Yr SL	490,568	13,457	()	504,025
14. Fixed equipment		-		()	-
15. Moveable equipment	5-8 Yr SL	501,854	6,728	()	508,582
16. Transportation vehicles		-		()	-
17. _____				()	-
18. _____				()	-
19. TOTAL ACCUMULATED DEPRECIATION		\$3,388,215		(\$-)	\$3,491,052
20. TOTAL DEPRECIATION EXPENSE			\$102,837		

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

SCHEDULE 35: Lease Expenses

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

A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (If known)	E. Lease Inception Date (MM/YY)	F. Describe Property	G. Lease Exp.
1. <u>HCCC, A WI Ltd Ptr</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<u>Aug-95</u>	<u>Building</u>	<u>\$530,568</u>
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				

SECTION B - LEASE EXPENSE FOR MOVEABLE EQUIPMENT AND OTHER LEASES

A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (If known)	E. Lease Inception Date (MM/YY)	F. Describe Property	G. Lease Exp.
4. <u>Office technology group</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<u>Jan-18</u>	<u>copier</u>	<u>\$5,861</u>
5. <u>Quadient</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<u>May-17</u>	<u>postage machine</u>	<u>1,100</u>
6. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
7. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
8. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
9. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
10. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
11. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
12. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
13. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				

SECTION C - TOTAL

14. TOTAL LEASE EXPENSE ON OPERATING LEASES AND NON-CAPITALIZED LEASES	<u>\$537,529</u>
---	-------------------------

SCHEDULE 36A: Capitalized Leases

SECTION A - CAPITALIZED LEASE INFORMATION

Lease Expense

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

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

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

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

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

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

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

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

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

SCHEDULE 36B: Capitalized Leases

SECTION B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

A1. Name of lessor _____

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

B1. Name of lessor _____

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

C1. Name of lessor _____

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

D1. Name of lessor _____

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

A2. Actual payments required by lease in report period _____

A4. If yes, (schedule) _____ (line) _____ (amount) _____

B2. Actual payments required by lease in report period _____

B4. If yes, (schedule) _____ (line) _____ (amount) _____

C2. Actual payments required by lease in report period _____

C4. If yes, (schedule) _____ (line) _____ (amount) _____

D2. Actual payments required by lease in report period _____

D4. If yes, (schedule) _____ (line) _____ (amount) _____

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

SCHEDULE 37: Property Taxes

SECTION A - FOR ALL PROVIDERS

1. 2020 Real Estate Tax Bill

Expense

2. 2020 Personal Property Tax Bill

739

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

Date(s) paid _____ Amount(s) paid _____ Amount still outstanding _____

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

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

SECTION B - FOR TAX-EXEMPT PROVIDERS ONLY

Expense

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

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

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

6. Describe the services provided by the municipality for the above fees. _____

7. TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE

\$739

SCHEDULE 37RP: Related Party Property Taxes

SECTION A - FOR ALL PROVIDERS

1. 2020 Real Estate Tax Bill

Expense

\$103,368

2. 2020 Personal Property Tax Bill

\$2,759

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

Date(s) paid _____ Amount(s) paid _____ Amount still outstanding _____

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

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

SECTION B - FOR TAX-EXEMPT PROVIDERS ONLY

Expense

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

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

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

6. Describe the services provided by the municipality for the above fees. _____

TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE

\$106,127

SCHEDULE 38 - NO LONGER USED

SCHEDULE 39 - NO LONGER USED

NURSING HOME COST REPORT SCHEDULES 38, 39

SCHEDULE 40: Allocated Property Expenses

	Areas for Non-NH Serv. Or Other Major Revenue-Generating Activities				
	A. Total From Sched.	B. NH Service Area	C.	D.	E.
SECTION A - DIRECT PROPERTY EXP.					
1. Property insurance (s31)	\$-				
2. Mortgage insurance (s31)	-				
3. Amortization debt premium discount (s32)	720				
4. Plant asset interest expense (s33)	-				
5. Depreciation land improvements (s34)	-				
6. Depreciation buildings (s34)	-				
7. Depreciation leasehold improve. (s34)	6,956				
8. Depreciation fixed equipment (s34)	-				
9. Depreciation moveable equip. (s34)	1,116				
10. Depreciation transportation veh. (s34)	-				
11. Depreciation other (s34)	9,057				
12. Expense on operating leases (s35)	537,529				
13. Expense on capitalized leases (s36)	-				
14. Property taxes or fees (s37)	739				
15. TOTAL EXPENSE	\$556,117	\$-			
16. Less total directly assigned property exp.	\$-				
17. NET UNASSIGNED/INDIRECT PROP.	\$556,117				
SECTION B - NON-SALARY EXPENSES					
18. Square feet of service's building area	42,452	42,452			
19. Ratio to total square feet to 4 decimals	1.0000	1.0000			
20. Indirect property expense allocation	\$556,117 (from 17A)	556,117 20A x 19B	-	-	-
			20A x 19C	20A x 19D	20A x 19E
SECTION C - TOTAL					
21. TOTAL PROP. EXP. FOR EACH AREA	\$556,117 17A + 20 A	\$556,117 15B + 20B	\$- 15C + 20C	\$- 15D + 20D	\$- 15E + 20E

SCHEDULE 41: Paid Time-Off Expenses

SECTION A - POLICIES AND PRACTICES

- 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.
- Capitalization of plant assets - briefly describe the facility's policy or practice for the capitalization of plant assets purchases. Assets value over \$1000 and a life over one year

Accrual

Cash

-
- Volunteer and unpaid employees - briefly explain if and how volunteer and other unpaid employee hours are reported in this cost report
Not applicable

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

SECTION B - NON-PRODUCTIVE SALARY EXPENSE AND HOURS

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

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

SECTION A - RELATED PARTY LEASES

Location and Amount of Expense Included in This Cost Report

<u>A. Description of Expense Item</u>	<u>B. Cost Ctr.</u>	<u>C. Schedule</u>	<u>D. Column</u>	<u>E. Line</u>	<u>F. Net Expense</u>
1. Total related party lease expense	property	35	g	1	\$(530,568)
2. Insurance expense	property	30p	a	9	63,876
3. Amortization deferred expense	property	32rp	g	5	1,114
4. Interest expense	property	33rp	h	1	142,019
5. Depreciation expense	property	34rp	c	20	102,837
6. Property tax expense	prop tax	37rp	0	0	106,127
7. _____	_____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____	_____
9. SUBTOTAL FOR RELATED PARTY LEASES					<u>\$(114,595)</u>

SECTION B - OTHER RELATED PARTY TRANSACTIONS

10. _____	_____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____	_____
15. TOTAL AMOUNT TO ADJUST RELATED PARTY TRANSACTIONS TO COST (to schedule 11, line 18)					<u>\$(114,595)</u>

SECTION C - IDENTIFICATION OF RELATED PARTIES

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

Lease of Building and Property with Care-Age of Brookfield Partnership

SCHEDULE 43: Identification of Expenses Not Related to Patient Care

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

SCHEDULE 43A - NO LONGER USED

SCHEDULE 44 - NO LONGER USED

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

SCHEDULE 46: Identification of Expenses for Employee Unique Fringe Benefits

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

SCHEDULE 49: Percentage of Ownership

	Name of Individual or Entity	Percentage of Ownership
1.	Patrick K. Murphy	25%
2.	Thaddeus Derynda	25%
3.		
4.		
5.		

SCHEDULE 50: Interest in Other Providers

	Name and City of Medicaid Provider	Type of Medical Services Provided	Nature and Extent of Interest in Provider
1.	Care-Age of Brookfield	SNF	Same as above
2.			
3.			
4.			
5.			

SCHEDULE 51 - NO LONGER USED

SCHEDULE 52: Miscellaneous Medicaid Non-Rate Revenues

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. TOTAL MISCELLANEOUS MEDICAID NON-RATE REVENUES	\$-		

SCHEDULE 53: Incentives – Private Room & Property

SECTION A - PRIVATE ROOM INCENTIVE

Indicate if your facility is requesting a private room incentive

Yes, my facility is requesting the private room incentive.

AFFIDAVIT				
I HEREBY ATTEST and affirm that from July 1, 2021, to June 30, 2022, the _____ nursing home will not charge/has not charged Medicaid residents any amount for private rooms including but not limited to the surcharge as provided under Ch DHS 107.09(4)(k), Wis. Admin. Rules. I furthermore acknowledge that all payments the facility has received for the Medicaid Private Room Incentive may be recouped retroactive to July 1, 2021, if the facility has charged Medicaid residents for private rooms during this period.				
SIGNATURE -	Original Signature of Officer or Administrator of Nursing Home	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 5px;">Title</td> <td style="width: 40%; padding: 5px;">Date</td> </tr> </table>	Title	Date
Title	Date			

SECTION B - PROPERTY INCENTIVE

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

YES

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

YES