# WISCONSIN MEDICAID PROGRAM 2020 NURSING HOME COST REPORT

## SCHEDULE 1: Facility & Preparer Information

### SECTION A - FACILITY INFORMATION

| Facility Name | Main Telephone Number | Main Email Address | |
|---|---|---|---|
| Oregon Manor LTD | 608-835-3535 | tom.l.r.graves@gmail.com | |
| **Facility Street Address** | **City** | **State** | **Zip Code** |
| 354 N Main Street | Oregon | WI | 53575 |

| Contact Person | Contact Telephone Number | Contact Email Address |
|---|---|---|
| Tom Graves | 608-393-6635 | tom.l.r.graves@gmail.com |

| Cost Report Period Start Date | Cost Report Period End Date | Medicaid Provider Number | National Provider Identifier (NPI) | POP ID Number |
|---|---|---|---|---|
| 1/1/2020 | 7/31/2020 | 100034556 | 1295178713 | 408 |

| Administrator | Chief Financial Officer | Where are the financial records of the nursing home located? |
|---|---|---|
| Tom Graves | | Oregon Manor |

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

| Name and Title | | Telephone Number | |
|---|---|---|---|
| JT and Associates, LLC | | 262-789-9945 | |
| **Address** | **City** | **State** | **Zip Code** |
| 700 Pilgrim Pkwy, Suite 200 | Elm Grove | WI | 53122 |
| 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 |
|---|---|---|
| | | |

# SCHEDULE 2: Provider Notes

Cost report was prepared with information provided by management. JT and Associates, LLC did not compile, review or audit the information provided by management and does not provide any assurance or opinion on the client financial statements.

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 3: General Information

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

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

3. County of facility: Dane — County Code: 13

4. Does the facility self-fund any of the fringe benefits reported on schedule 28? If yes, complete Schedule S-F FB. [ ] (1) Yes [X] (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.

If there has been a change in the number of licensed beds, list the date(s) of the change(s), the number of beds and briefly explain.

| | DATE | BEDS |
|---|---|---|
| Beds at Beginning of Cost Reporting Period | 1/1/2020 | 45 |
| Beds at End of Cost Reporting Period | 7/31/2020 | 45 |
| | | |
| | | |

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 [X] (2) No

8. Check all related party transaction types for which expenses are reported.
[X] (1) Related party lease of building [X] (2) Compensation to owners/family relation
[X] (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? [X] 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? [X] 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. | Oregon Manor LTD | 2604 | 1 | 44 | 45 |
| 2. | | | | | - |
| 3. | | | | | - |
| 4. | TOTAL | | 1 | 44 | 45 |

**Medicaid PopID & Provider Number** 408-100034556

## 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: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Hospital, Name of hospital:<br>Beds at end of cost report period: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Non-Medicaid Nursing Home, Beds at end of cost report period: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Non-Medicaid CBRF, Beds at end of cost report period: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Apartment units, Beds at end of cost report period: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Room and Board - Other, Beds at end of cost report period: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Therapy services, Describe: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Pharmacy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Laboratory or radiology services | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Rental of building space | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Adult Day Care | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Home Health | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Food catering services (meals on wheels, etc.) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. Child care | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Clinic | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. Other, Describe: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. Any items checked in this column x = Yes blank = No | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## SCHEDULE 5 - NO LONGER USED

# SCHEDULE 6: Total Patient Days

## SECTION A - INHOUSE PATIENT DAYS

| | | LEVEL OF CARE (LOC) NON DD | DD | TOTAL |
|---|---|---|---|---|
| 1a. | Medicaid (T-19) | 3,091 | | 3,091 |
| 1b. | ICF-IID Medicaid (T-19) | | | - |
| 1c. | Family Care (T-19) | 1,073 | | 1,073 |
| 1d. | Other Medicaid Managed Care (T-19) | | | - |
| 1e. | Hospice (T-19) | 183 | | 183 |
| 1f. | Ventilator (T-19) | | | - |
| 2a. | Medicare (T-18) | 239 | | 239 |
| 2b. | Medicare Advantage, for days covered as a Part A stay | 18 | | 18 |
| 3a. | Private pay & Insurance | 1,059 | | 1,059 |
| 3b. | Medicare Advantage, for days not covered as a Part A stay | | | - |
| 3c. | Hospice (Private pay & Insurance) | | | - |
| 4. | Other, Specify: | | | |
| 5. | TOTAL INHOUSE PATIENT DAYS | 5,663 | - | 5,663 |

## 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** | **5,663** | **-** | **5,663** |

**Medicaid PopID & Provider Number** 408-100034556

## 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 | | | | | | **TOTAL** |
| 2. | Days in Month . . . . . | 31 | 29 | 31 | 30 | 31 | 30 | 31 | | | | | | 213 |
| 3. | Licensed Beds for Bed Hold Testing. . . . | 45 | 45 | 45 | 45 | 45 | 45 | 45 | 45 | 45 | 45 | 45 | 45 | 540 |
| 4. | Occupancy Test: | | | | | | | | | | | | | |
| | Row 2 x (Row 3 x 94%) | 1,311 | 1,227 | 1,311 | 1,269 | 1,311 | 1,269 | 1,311 | | | | | | 9,009 |
| 5. | Inhouse patient days | 847 | 745 | 849 | 797 | 781 | 779 | 865 | - | - | - | - | - | 5,663 |
| 6. | Bed Hold days . . . . | - | - | - | - | - | - | - | - | | - | - | - | - |
| 7. | **TOTAL DAYS . . .** | 847 | 745 | 849 | 797 | 781 | 779 | 865 | | | | | | 5,663 |
| | | n/a | Fail | Fail | Fail | Fail | Fail | Fail | Fail | Pass | Pass | Pass | Pass | |

Explanation for why Licensed Beds for Bed Hold Testing are less than Licensed Beds: 0

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

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 10: Balance Sheet

| ASSETS | Begin Date 1/1/20 | End Date 7/31/20 |
|---|---|---|
| **CURRENT ASSETS** | | |
| Cash on hand and in bank | $45,792 | $163,507 |
| Temporary investments | | |
| Resident accounts receivable | 543,227 | |
| Other accounts receivable | | |
| Due from related parties | | |
| Notes receivable | | |
| Accrued interest receivable | | |
| Inventories | 7,094 | |
| Prepaid expenses | 15,260 | |
| Resident funds held in trust | | |
| Other current assets, list below: | | |
| | | |
| | | |
| TOTAL CURRENT ASSETS | $611,373 | $163,507 |
| **PROPERTY, PLANT, EQUIP.** | | |
| Land | | |
| Land improvements | 248,419 | 248,419 |
| Buildings | | |
| Leasehold improvements | 53,136 | 53,136 |
| Fixed equipment | | |
| Moveable equipment | 230,343 | 230,343 |
| Transportation equipment | 15,989 | 15,989 |
| Other | | |
| Less: accumulated depreciation | ( 299,984 ) | ( 296,588 ) |
| TOTAL PROPERTY, PLANT, EQUIPMENT | $247,903 | $251,299 |
| **OTHER** | | |
| Long term investments | | |
| Other Assets, list below: | | |
| Loan Costs | 116 | - |
| | | |
| TOTAL OTHER ASSETS | $116 | $- |
| **TOTAL ASSETS** | $859,392 | $414,806 |

| LIABILITIES AND OWNERS' EQUITY | Begin Date 1/1/20 | End Date 7/31/20 |
|---|---|---|
| **CURRENT LIABILITIES** | | |
| Notes and loans payable, list below: | | |
| | | |
| | | |
| | | |
| | | |
| Due to related parties | 27,240 | 94,883 |
| Accounts payable | 219,601 | |
| Accrued salaries | 76,444 | |
| Other accrued expenses | 54,225 | 503,370 |
| Resident trust funds payable | | |
| Other current liabilities | | |
| TOTAL CURRENT LIABILITIES | $377,510 | $598,253 |
| **LONG TERM LIAB.** | | |
| Notes and loans payable (list) below: | | |
| Notes Payable | 885,628 | 691,261 |
| | | |
| | | |
| Other long term liabilities | | |
| TOTAL LONG TERM LIABILITIES | $885,628 | $691,261 |
| **OWNER EQUITY** | | |
| OWNERS' EQUITY, list below: | | |
| Common Stock | (403,746) | (874,708) |
| | | |
| | | |
| TOTAL OWNER'S EQUITY | $(403,746) | $(874,708) |
| **TOTAL LIABILITIES AND EQUITY** | $859,392 | $414,806 |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 10A: Summary of Changes to Equity

| | | | | |
|---|---|---|---|---|
| 1. | Beginning Owners' Equity (from schedule 10) | | | $(403,746) |
| 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: Prior Period Adj/Depr Adj | 85,577 | |
| | | Other, Specify: Related Party | 19,278 | |
| | | Total additions | | 104,855 |
| 3. | Deduct | Net loss (from schedule 11, line 19) | ($575,145) | |
| | | Dividends and withdrawals | ( ) | |
| | | Net increase in accrued vacation, holiday and sick time | ( ) | |
| | | Other, Specify: FICA | (672) | |
| | | Other, Specify: | (-) | |
| | | Total deductions | | (575,817) |
| **4.** | **ENDING OWNERS' EQUITY (schedule 10).** | | | $(874,708) |

# 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 | $ 1,330,952 |
| 2. | Service fees | schedule 15, line 14A | 8,357 |
| 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 | 303 |
| 7. | Rental revenues | schedule 17, line 22 | - |
| 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 | - |
| 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 | 250 |
| 14. | Other revenue | schedule 18, line 50 | 471,837 |
| 15. | Subtract: deductions from revenues | schedule 14, line 5 | ( 189,417 ) |
| 16. | NET REVENUES | | $ 1,622,282 |

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

| | | | |
|---|---|---|---|
| 17. | Subtract: total expenses | schedule 12, line 37 | $ ( 2,178,149 ) |
| 18. | Add or subtract the amount to adjust related party transactions to cost | schedule 42, line 15 | (19,278) |
| **19.** | **NET INCOME OR LOSS** | | $ **(575,145)** |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 12: Summary of Total Expenses

All values are automatically posted from other schedules.

| Cost Center | Reference | Expense |
|---|---|---|
| 1. Daily patient service expense | S20, L10 | $960,501 |
| 2. Laboratory & Radiology | S21, L13a | 8,906 |
| 3. Respiratory | S21, L13b | - |
| 4. Pharmacy | S21, L13c | 4,167 |
| 5. PT, OT and Speech | S22, L13a | 66,639 |
| 6. Dental | S22, L13b | - |
| 7. Physician | S22, L13c | - |
| 8. Social Services | S23, L13a | 25,648 |
| 9. Recreational Activities | S23, L13b | 119,483 |
| 10. Religious Services | S23, L13c | - |
| 11. Volunteer Coordinator | S24, L13a | - |
| 12. Ward Clerks | S24, L13b | - |
| 13. Psychotherapy | S24, L13c | - |
| 14. Other | S24, L13d | |
| 15. Dietary | S25, L14a | 183,290 |
| 16. Plant Operations and Maintenance | S25, L14b | 78,895 |
| 17. Housekeeping | S25, L14c | 49,365 |
| 18. Laundry and Linen | S25, L14d | 21,464 |
| 19. Security | S25, L14e | - |

| Cost Center | Reference | Expense |
|---|---|---|
| 20. Transportation | S25, L14f | $6,110 |
| 21. Administrative service expense | S26, L12 | 292,186 |
| Other cost centers, Specify: | | |
| 22. Nurse Aide Training | S27, L16a | |
| 23. Beauty/Barber Shop | S27, L16b | |
| 24. 0 | S27, L16c | |
| 25. 0 | S27, L16d | |
| 26. 0 | S27, L16e | |
| UNASSIGNED EXPENSES | | |
| 27. Employee fringe benefit expense | S28, L17 | 230,663 |
| 28. Heating fuel and utility expense | S29, L10 | 28,263 |
| 29. Interest on operating working capital loans | S30, L6 | - |
| 30. Insurance expense | S31, L9 | 10,818 |
| 31. Amortization expense | S32, L5 | 116 |
| 32. Interest on plant asset loans | S33, L15h | - |
| 33. Depreciation expense | S34, L20c | 14,143 |
| 34. Expense on operating and non-cap.leases | S35, L14 | 52,500 |
| 35. Expense on capitalized leases | S36A, L5 | - |
| 36. Property tax expense | S37, L7 | 24,992 |
| **37. TOTAL EXPENSES FOR REPORT PERIOD** | | $2,178,149 |

(To schedule 11, line 17)

**Medicaid PopID & Provider Number** 408-100034556

# 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 | $657,084 | Dietary | S25, L1a | 113,149 |
| Laboratory & Radiology | S21, L1a | - | Plant operation / maintenance | S25, L1b | 32,250 |
| Respiratory | S21, L1b & 3b | - | Housekeeping | S25, L1c | 43,838 |
| Pharmacy | S21, L1c & 3c | - | Laundry and Linen | S25, L1d | 19,383 |
| PT, OT and Speech | S22, L1a &3a | - | Security | S25, L1e | - |
| Dental | S22, L1b &3b | - | Transportation | S25, L1f | - |
| Physician | S22, L1c &3c | - | Administrative service | S26, L5 | 111,922 |
| Social Services | S23, L3a | 25,648 | Nurse aide training | S27, L1a | - |
| Recreational Activities | S23, L3b | 61,677 | 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 | - | 0 | S27, L1e | - |
| Psychotherapy | S24, L1c & 3c | - | **TOTAL SALARY AND WAGE EXPENSE** | | $1,064,951 |
| Other | S24, L1d & 3d | - | | | |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 14: Daily Patient Service Revenues

| **SECTION A - DAILY RATE CHARGES** | **Revenue** |
|---|---|
| 1. Medicare Daily Rate | $140,960 |
| 2. Medicaid Daily Rate (including bed hold) | 787,162 |
| 3. Private Pay | 402,830 |
| 4. Medical Supplies,Other | |

| **SECTION B - Deductions From Revenue** | |
|---|---|
| 5. TOTAL DEDUCTIONS FROM REVENUE | ( 189,417 ) |

| **SECTION C - TOTAL** | |
|---|---|
| 6. TOTAL DAILY PATIENT SERVICE REVENUE | $1,141,535 |

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

- [X] 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 $303.00
8. Facility Comment (Optional)

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 15: Special Services Revenue

## SECTION A - SERVICE REVENUES

| | | A. Service Fee Charges | B. Rent from Outside Medical Providers | C. From Other Sources | Describe Other |
|---|---|---|---|---|---|
| 1. | Laboratory | | | | |
| 2. | Radiology | 3,198 | | | |
| 3. | Pharmacy | 5,159 | | | |
| 4. | Physical therapy | | | | |
| 5. | Speech/hearing therapy | | | | |
| 6. | Occupational therapy | | | | |
| 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 | $8,357 | $- | $- | |

## SECTION B - THERAPY REVENUES

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

16. Total gross billings for physical, occupational, and speech therapy services provided at your facility during the cost report period $-
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) $-

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

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

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 16: Other Revenues

## SECTION A - CAFETERIA AND DIETARY REVENUE

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

## SECTION B - MISCELLANEOUS SERVICES AND MATERIALS

| | | | Expenses Directly Ascribable To Or Identifiable With Revenue | | | |
|---|---|---|---|---|---|---|
| | | Revenue | A. Related Direct Expense (if known) | B. Cost Center where expense included | C. Schedule Number | D. Line Number |
| 6. | Laundry | | | | | |
| 7. | Sale of personal hygiene items | | | | | |
| 8. | Transportation | | | | | |
| 9. | Beauty and barber shops | | | | | |
| 10. | Gift Shop | | | | | |
| 11. | Canteen and snack counter | | | | | |
| 12. | Vending machines | 303 | | | | |
| 13. | Sale of clothing | | | | | |
| 14. | Television and cable service | | | | | |
| 15. | Telephone and Internet | | | | | |
| **16.** | **TOTAL MISCELLANEOUS SERVICES AND MATERIALS** | **$303** | | | | |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 17: Other Revenues

| SECTION A - RENTAL REVENUE | Revenue | Property Rented | Square Feet Rented | Services Provided |
|---|---|---|---|---|
| 18. Equipment rental | | | | |
| 19. Rental of nursing home space | | | | |
| 20. Rental of non-nursing home space | | | | |
| 21. Parking | | | | |
| **22. TOTAL RENTAL REVENUES** | $- | | | |

| SECTION B - REVENUE FROM MAJOR ACTIVITIES | Revenue | Total Billable Patient Days if revenue generated from activities |
|---|---|---|
| 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 | |
| 43. | TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS | |
| 44. | TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES | |
| 45. | TOTAL GRANTS, CONTRIBUTIONS, DONATIONS | $250 |
| | OTHER REVENUES | |
| 46. | OTHER INCOME | $463,122 |
| 47. | WORKMAN'S COMP REFUND | 8,715 |
| 48. | | |
| 49. | | |
| 50. | TOTAL OTHER REVENUES | $471,837 |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 20: Daily Patient Service Expense

| Salaries, Wages & Purchased Serv. | A. Registered Nurses | B. Licensed Practical Nurses | C. Nurse Aides and Assistants | D. Total Expenss or Hours |
|---|---|---|---|---|
| 1. TOTAL SALARY AND WAGE EXPENSE | $284,098 | $108,764 | $264,222 | $657,084 |
| 2. TOTAL SALARY AND WAGE HOURS | 11,114 hrs. | 6,614 hrs. | 26,096 hrs. | $43,824 |
| 3. EXPENSE FOR PURCHASED SERVICES | | | $214,563 | $214,563 |
| AVERAGE WAGE PER HOUR | $25.56 | $16.44 | $10.13 | $14.99 |

## NURSING AND INCONTINENCY SUPPLIES

| | | |
|---|---|---|
| 4. | Catheters, Incontinency Supplies (including purchased laundry service) | $6,511 |

## OXYGEN

| | | |
|---|---|---|
| 5. | Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental | |

## OTHER

| | | |
|---|---|---|
| 6. | Other medical supplies, personal comfort supplies and minor medical equipment | 59,073 |
| 7. | Nonbillable over the counter (OTC) drugs for all residents (include billable OTC drugs on Schedule 21, Line 9c) | 23,270 |
| 8. | | |
| 9. | | |
| **10.** | **TOTAL DAILY PATIENT SERVICE EXPENSE** | **$960,501** |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 21: Special Service Expenses

| | | TYPE OF SERVICE | | |
|---|---|---|---|---|
| **SECTION A - SALARY AND WAGES** | **A. Laboratory & Radiology** | **B. Respiratory** | **C. Pharmacy** |
| 1. Expense for hours worked - Billable | | | |
| 2. Number of hours worked - Billable | | | |
| 3. Expense for hours worked - Non-billable | $- | | |
| 4. Number of hours worked - Non-billable | hrs. | | |
| 5. TOTAL SALARY AND WAGE EXPENSE | $- | $- | $- |
| **SECTION B - PURCHASED SERVICES** | | | |
| 6. Expense for purchased service - Billable | $8,906 | | |
| 7. Expense for purchased service - Non billable | $- | | |
| **SECTION C - SUPPLY AND OTHER EXPENSE** | | | |
| 8. Pharmacy - legend drugs Billable | $- | $- | 4,167 |
| 9. Pharmacy - over the counter drugs Billable | $- | $- | |
| 10. Supply and Other | | | |
| 11. | | | |
| 12. | | | |
| **SECTION D - TOTAL** | | | |
| **13. TOTAL EXPENSES** | **$8,906** | **$-** | **$4,167** |
| **14. TOTAL HOURS** | **hrs.** | **hrs.** | **hrs.** |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 22: Special Service Expenses

| | | TYPE OF SERVICE | | |
|---|---|---|---|---|
| **SECTION A - SALARY AND WAGES** | | **A. Physical, Occupational And Speech Therapy** | **B. Dental** | **C. Physician** |
| 1. | Expense for hours worked - Billable. . . . . | | | |
| 2. | Number of hours worked - Billable. . . . . | | | |
| 3. | Expense for hours worked - Non-billable. . . . . | | | |
| 4. | Number of hours worked - Non-billable. . . . . | | | |
| 5. | TOTAL SALARY AND WAGE EXPENSE | $- | $- | $- |
| **SECTION B - PURCHASED SERVICES** | | | | |
| 6. | Expense for purchased service - Billable . . . . . | $66,639 | | |
| 7. | Expense for purchased service - Non billable . . . . . | | | |
| **SECTION C - SUPPLY AND OTHER EXPENSE** | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. | | | | |
| **SECTION D - TOTAL** | | | | |
| 13. | TOTAL EXPENSES . . . . . | $66,639 | $- | $- |
| 14. | TOTAL HOURS . . . . . | hrs. | hrs. | hrs. |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 23: Special Service Expenses

| | | TYPE OF SERVICE | | |
|---|---|---|---|---|
| **SECTION A - SALARY AND WAGES** | | **A. Social Services** | **B. Recreational Activities** | **C. Religious Services** |
| 1. | Expense for hours worked - Billable | $- | $- | $- |
| 2. | Number of hours worked - Billable | hrs. | hrs. | hrs. |
| 3. | Expense for hours worked - Non-billable | $25,648 | $61,677 | |
| 4. | Number of hours worked - Non-billable | 1,213 hrs. | 2,818 hrs. | |
| 5. | TOTAL SALARY AND WAGE EXPENSE | $25,648 | $61,677 | $- |
| **SECTION B - PURCHASED SERVICES** | | | | |
| 6. | Expense for purchased service - Billable . . . . . | $- | $- | $- |
| 7. | Expense for purchased service - Non billable . . . . . | | | |
| **SECTION C - SUPPLY AND OTHER EXPENSE** | | | | |
| 8. | SUPPLIES | | $57,806 | |
| 9. | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. | | | | |
| **SECTION D - TOTAL** | | | | |
| **13.** | **TOTAL EXPENSES . . . . . .** | **$25,648** | **$119,483** | **$-** |
| **14.** | **TOTAL HOURS . . . . . .** | **1,213 hrs.** | **2,818 hrs.** | **hrs.** |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 24: Special Service Expenses

| | | TYPE OF SERVICE | | | |
|---|---|---|---|---|---|
| **SECTION A - SALARY AND WAGES** | | **A. Volunteer Coord.** | **B. Ward Clerks** | **C. Psychotherapy** | |
| 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 | $- | $- | $- | $- |
| **SECTION B - PURCHASED SERVICES** | | | | | |
| 6. | Expense for purchased service - Billable . . . . . | | | | |
| 7. | Expense for purchased service - Non billable . . . . . | | | | |
| **SECTION C - SUPPLY AND OTHER EXPENSE** | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | | | | | |
| 12. | | | | | |
| **SECTION D - TOTAL** | | | | | |
| **13.** | **TOTAL EXPENSES** . . . . . | $- | $- | $- | |
| **14.** | **TOTAL HOURS** . . . . . | hrs. | hrs. | hrs. | hrs. |

**Medicaid PopID & Provider Number** 408-100034556

# 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 | $113,149 | $32,250 | $43,838 | $19,383 | | |
| 2. NUMBER OF HOURS WORKED | 7,467 hrs. | 1,369 hrs. | 3,258 hrs. | 1,253 hrs. | | |
| **SECTION B - DIETICIAN CONSULTANT** | | | | | | |
| 3. Dietician consultant expense | $3,219 | $- | $- | $- | $- | $- |
| **SECTION C - OUTSIDE SERVICE** | | | | | | |
| 4. CONTRACTED SERVICES | | $18,740 | | | | $6,110 |
| 5. | | | | | | |
| 6. | | | | | | |
| 7. | | | | | | |
| 8. **TOTAL OUTSIDE SERVICE EXPENSES** | $- | $18,740 | $- | $- | $- | $6,110 |
| **SECTION D - SUPPLY AND OTHER EXPENSE** | | | | | | |
| 9. FOOD | $60,044 | | | | | |
| 10. SUPPLIES | 6,878 | 24,301 | 5,527 | 2,081 | | |
| 11. REPAIRS AND MAINETANCE | | 3,337 | | | | |
| 12. LANDSCAPING | | 267 | | | | |
| 13. | | | | | | |
| **SECTION E - TOTAL** | | | | | | |
| **14. TOTAL EXPENSES** | **$183,290** | **$78,895** | **$49,365** | **$21,464** | **$-** | **$6,110** |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 25A: Support Services Expense Allocations

## SECTION A - ALLOCATION OF DIETARY EXPENSES

| | | |
|---|---|---|
| 1. | Total dietary expenses (from Schedule 25, Line 14a) | $183,290 |
| 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) | $183,290 |

| | | A. Total | B. Residents' Meals | C. Employees' Meals | D. Meals on Wheels | E.Other MAIN STREET QUARTERS | F. Other |
|---|---|---|---|---|---|---|---|
| 6. | Meals served | 19,790 | 16,898 | | | 2,892 | |
| 7. | Ratio to total meals served to 4 decimals | 1.0000 | 0.8539 | | | 0.1461 | |
| 8. | DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete) | $183,290 From line 5 | $156,511 8A x 7B | $- 8A x 7C | $- 8A x 7D | $26,779 8A x 7E | $- 8A x 7F |

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

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

| | | A. Total Area | B. Nursing Home Area | C. Emp. Unique Fringe Benefit Area | Non-Nursing Home Areas w/ Plant Operation and Maint. D. | E. | F. |
|---|---|---|---|---|---|---|---|
| 12. | Total square feet for areas | 18,680 | 18,680 | | | | |
| 13. | Ratio to total square feet to 4 decimals . . | 1.0000 | 1.0000 | | | | |
| 14. | TOTAL PATIENT OP/MAINT EXP. ALLOC. | $78,895 From S25, L18 | $78,895 14A x 13B | $- 14A x 13C | $- 14A x 13D | $- 14A x 13E | $- 14A x 13F |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 25B: Support Services Expense Allocations

## SECTION A - ALLOCATION OF HOUSEKEEPING EXPENSES

| | | A. Total | B. Nursing Home Area | Non-Nursing Home Areas Receiving Housekeeping Services | | |
|---|---|---|---|---|---|---|
| 15. | Square feet or hours of service provided | 18,680 | 18,680 | | | |
| 16. | Ratio to total sq. ft./hours to 4 decimals | 1.0000 | 1.0000 | | | |
| 17. | TOTAL HOUSEKEEPING EXP. ALLOC. | $49,365 | $49,365 | $- | $- | $- |
| | | From S25, L18 | 17A x 16B | 17A x 16C | 17A x 16D | 17A x 16E |

## SECTION B - ALLOCATION OF LAUNDRY AND LINEN EXPENSES

| | | A. Total | B. Nursing Home Area | Non-Nursing Home Areas Receiving Laundry/Linen Services | | |
|---|---|---|---|---|---|---|
| 18. | Pounds of laundry processed | 18,680 | 18,680 | | | |
| 19. | Ratio to total pounds to 4 decimals . . . . . | 1.0000 | 1.0000 | | | |
| 20. | TOTAL LAUNDRY/LINEN EXP. ALLOC. | $21,464 | $21,464 | $- | $- | $- |
| | | From S25, L18 | 20A x 19B | 20A x 19C | 20A x 19D | 20A x 19E |

## SECTION C - ALLOCATION OF SECURITY EXPENSES

| | | A. Total | B. Nursing Home Area | Non-Nursing Home Areas Receiving Security Services | | |
|---|---|---|---|---|---|---|
| 21. | Total square feet of area | - | | | | |
| 22. | Ratio to total square feet to 4 decimals . . | 1.0000 | | | | |
| 23. | TOTAL SECURITY EXPENSE ALLOC. | | $- | $- | $- | $- |
| | | From S25, L18 | 23A x 22B | 23A x 22C | 23A x 22D | 23A x 22E |

## SECTION D - ALLOCATION OF TRANSPORTATION EXPENSES

| | | A. Total | B. Nursing Home Area | Non-Nursing Home Areas Receiving Transportation Services | | |
|---|---|---|---|---|---|---|
| 24. | Alloc. Basis, Specify: SQ FT | 18,680 | 18,680 | | | |
| 25. | Ratio to total alloc. basis to 4 decimals | 1.0000 | 1.0000 | | | |
| 26. | TOTAL TRANS. EXPENSE ALLOC. | $6,110 | $6,110 | $- | $- | $- |
| | | 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 | $86,970 |
| 2. | Medical Records | 24,952 |
| 3. | Central Supply | |
| 4. | Scheduling | |
| 5. | Total Salary and Wage Expense | $111,922 |
| **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 | 57,925 |
| 10. | Contractual management fees | |
| 11. | Total other non-salary (from schedule 26 attachment) | 122,339 |
| **SECTION D - TOTAL** | | |
| 12. | TOTAL ADMINISTRATIVE SERVICE EXPENSES | $292,186 |

**Medicaid PopID & Provider Number** 408-100034556

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

| | Description of Other Non-Salary Administrative Service Expenses | Expense Amount |
|---|---|---|
| 1. | ACCOUNTING | $5,400 |
| 2. | BACKGROUND CHECKS | 340 |
| 3. | ADVERTISING | 924 |
| 4. | TELEPHONE | 2,137 |
| 5. | BANK FEES | 1,370 |
| 6. | CONSULTANTS | 9,136 |
| 7. | CABLE SERVICES | 3,422 |
| 8. | DATA PROCESSING | 60,699 |
| 9. | DUES & SUBSCRIPTIONS | 11,303 |
| 10. | OFFICE SUPPLIES | 27,608 |
| 11. | | |
| 12. | | |
| 13. | | |
| 14. | | |
| 15. | | |
| **16.** | **TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11) . . . . . .** | **$122,339** |

# 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 | $- |

**Medicaid PopID & Provider Number** 408-100034556

# 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).** . . . . . | **$-** |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 26B: Allocation of Administrative Expenses

1. Total Admin. Service Expense (S26, 12) $292,186

## SECTION A - DIRECT EXPENSES

| Exp. Directly Ascribable To Each Activity | A. Total | B. NH Provider | Non-Nursing Home Areas Receiving Administrative Services | | |
|---|---|---|---|---|---|
| 2. | $- | $- | | | |
| 3. | - | | | | |
| 4. | - | | | | |
| 5. | - | | | | |
| 6. | - | | | | |
| 7. | - | | | | |
| 8. | - | | | | |
| 9. | - | | | | |
| 10. | - | | | | |
| 11. | - | | | | |
| 12. | - | | | | |
| 13. | - | | | | |
| 14. | - | | | | |
| 15. TOTAL DIRECT EXPENSE. . . . . | $- | $- | | | |
| 16. NET UNASSIGNED EXPENSE | $292,186 | | | | |

## 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 . . . . . | $292,186 | 292,186 | - | - | - |
| | net from line 16 | 19A x 18B | 19A x 18C | 19A x 18D | 19A x 18E |
| 20. TOTAL ADMINISTRATIVE EXPENSE . . . . . | $292,186 | $292,186 | $- | $- | $- |
| | (line 15A + 19A) | B15 + B19 | C15 + C19 | D15 + D19 | E15 + E19 |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 27: Other Cost Centers

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

| **SECTION B - NON-SALARY EXPENSES** | **A. Nurse Aide Training** | **B. Beauty/Barber Shop** | - | - | - |
|---|---|---|---|---|---|
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
| 11. | | | | | |
| 12. | | | | | |
| 13. | | | | | |
| 14. | | | | | |
| 15. **TOTAL NON-SALARY EXPENSES** | $- | $- | $- | $- | $- |

| **SECTION C - TOTAL** | **A. Nurse Aide Training** | **B. Beauty/Barber Shop** | - | - | - |
|---|---|---|---|---|---|
| **16. TOTAL EXPENSES . . . . . .** | | | | | |

# SCHEDULE 28: Fringe Benefits

| | Fringe Benefits Paid on Behalf of Employees | Self-Funded? | Expense |
|---|---|---|---|
| 1. | Employer's share of F.I.C.A. | | $84,519 |
| 2. | State unemployment compensation | | 2,633 |
| 3. | Federal unemployemnt compensation | | 2,765 |
| 4. | Worker's compensation insurance | ☐ Yes ☒ No | 56,935 |
| 5. | Health, Dental & Vision Insurance | ☐ Yes ☒ No | 67,172 |
| 6. | Life and disability insurance | ☐ Yes ☒ No | 1,586 |
| 7. | Wage continuation insurance | ☐ Yes ☐ No | |
| 8. | Pension and deferred comp. plans (section C) | ☐ Yes ☐ No | |
| 9. | Post-Employment Physicals and Vaccines | | 282 |
| 10. | Uniforms | | |
| 11. | EMPLOYEE WELFARE | | 14,771 |
| 12. | | | |
| 13. | | | |
| 14. | | | |
| 15. | TOTAL PAID ON BEHALF OF EMPLOYEES | | $230,663 |
| 16. | Expense for special salary or wage payments to employees not included elsewhere | | |

- ☐ Christmas bonus
- ☐ Longevity bonus
- ☐ Productivity bonus
- ☐ Bonuses to owners and immediate family relations, Specify:

- ☐ Other, Specify:

| | | |
|---|---|---|
| **17.** | **TOTAL FRINGE BENEFIT EXPENSE** | **$230,663** |

**Medicaid PopID & Provider Number** 408-100034556

# 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) | $- | $- | $- | $- | $- |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 29: Heating and Utility Service Expenses

## SECTION A - ACCRUED EXPENSE BY TYPE

| | Expense by Type | Accrued Expense |
|---|---|---|
| 1. | Fuel oil | |
| 2. | Natural gas | |
| 3. | L.P. gas | |
| 4. | Coal | |
| 5. | Electricity | |
| 6. | Water and sewer utility charges | |
| 7. | Purchased steam | |
| 8. | UTILITIES | 28,263 |
| 9. | | |
| **10.** | **TOTAL FUEL AND UTILITY EXPENSE . . .** | **$28,263** |

## 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 | 18,680 | 18,680 | | | | |
| 12. | Ratio to total square feet to 4 decimals | 1.0000 | 1.0000 | | | | |
| **13.** | **TOTAL ALLOC. FUEL/UTIL. EXPENSE** | **28,263** | **$28,263** | **$-** | **$-** | **$-** | **$-** |
| | | 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. | | ☐ Yes ☐ No | |
| 2. | | ☐ Yes ☐ No | |
| 3. | | ☐ Yes ☐ No | |
| 4. | | ☐ Yes ☐ No | |
| 5. | | ☐ Yes ☐ 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 | ☐ Yes ☒ No | $6,491 |
| 2. | Automobile insurance | ☐ Yes ☐ No | |
| 3. | Liability insurance | ☐ Yes ☒ No | 4,327 |
| 4. | Business interruption insurance | ☐ Yes ☐ No | |
| 5. | Life insurance on owners and employes with facility as the beneficiary | ☐ Yes ☐ No | |
| 6. | Mortgage insurance | ☐ Yes ☐ No | |
| 7. | Other Property | ☐ Yes ☐ No | |
| 8. | Other General | ☐ Yes ☐ No | |
| 9. | **TOTAL INSURANCE EXPENSE.** | | **$10,818** |

## 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. | LOAN COSTS | 0 | $6,970 | 5 | $116 | $- | $116 |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | **TOTAL AMORTIZATION EXPENSE** | | | | | | **$116** |

## SCHEDULE 30RP: Related Party Working Capital Loans

| | A. Name of Lender | B. Is Lender a Related Party? | C. Interest Expense |
|---|---|---|---|
| 1. | | ☐ Yes ☐ No | |
| 2. | | ☐ Yes ☐ No | |
| 3. | | ☐ Yes ☐ No | |
| 4. | | ☐ Yes ☐ No | |
| 5. | | ☐ Yes ☐ 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 | ☐ Yes ☐ No | |
| 2. | Automobile insurance | ☐ Yes ☐ No | |
| 3. | Liability insurance | ☐ Yes ☐ No | |
| 4. | Business interruption insurance | ☐ Yes ☐ No | |
| 5. | Life insurance on owners and employes with facility as the beneficiary | ☐ Yes ☐ No | |
| 6. | Mortgage insurance | ☐ Yes ☐ No | |
| 7. | | ☐ Yes ☐ No | |
| 8. | | ☐ Yes ☐ No | |
| **9.** | **TOTAL INSURANCE EXPENSE** | | **$-** |

## SCHEDULE 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. | LOAN COST | 0 | $3,719 | 5 | $1,611 | $1,177 | $434 |
| 2. | LOAN COST REFINANCING | 0 | 12,345 | 10 | 8,951 | 8,231 | 720 |
| 3. | | | | | | | |
| 4. | | | | | | | |
| **5.** | **TOTAL AMORTIZATION EXPENSE** | | | | | | **$1,154** |

**Medicaid PopID & Provider Number** 408-100034556

# 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 D. Begin date 1/1/2020 Begin Bal. | E. 6Mo.date 4/30/2020 6 Mo. Bal. | F. End date 7/31/2020 End Bal. | G. Interest Rate | H. Interest Expense |
|---|---|---|---|---|---|---|---|---|
| 1. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 2. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 3. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 4. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 5. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 6. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 7. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| **15 TOTAL LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2)** | | | | $- | $- | $- | | $- |

Medicaid PopID & Provider Number 408-100034556

## 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 D. Begin date 1/1/2020 Begin Bal. | E. 6Mo.date 4/30/2020 6 Mo. Bal. | F. End date 7/31/2020 End Bal. | G. Interest Rate | H. Interest Expense |
|---|---|---|---|---|---|---|---|---|
| 8. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 9. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 10. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 11. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 12. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 13. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 14. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |

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

**Medicaid PopID & Provider Number** 408-100034556

## 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 D. Begin date 1/1/2020 Begin Bal. | E. 6Mo.date 4/30/2020 6 Mo. Bal. | F. End date 7/31/2020 End Bal. | G. Interest Rate | H. Interest Expense |
|---|---|---|---|---|---|---|---|---|
| 1. Name RICK SCOLLON<br>Related party? [ ] Yes [X] No<br>Purpose | Jan-13 | Dec-16 | $1,859,895 | $1,305,307 | $- | $1,281,307 | 3.00% | $22,423 |
| 2. Name TOM GRAVES<br>Related party? [X] Yes [ ] No<br>Purpose | Jan-13 | Dec-16 | $513,534 | $316,005 | $- | $245,705 | 12.00% | $- |
| 3. Name OREGON COMMUNITY BA<br>Related party? [ ] Yes [X] No<br>Purpose | Apr-17 | Jun-37 | $527,538 | $495,362 | $- | $412,241 | 2.86% | $11,976 |
| 4. Name<br>Related party? [ ] Yes [ ] No<br>Purpose | | | | | | | | |
| 5. Name<br>Related party? [ ] Yes [ ] No<br>Purpose | | | | | | | | |
| 6. Name<br>Related party? [ ] Yes [ ] No<br>Purpose | | | | | | | | |
| 7. Name<br>Related party? [ ] Yes [ ] No<br>Purpose | | | | | | | | |
| **15 TOTAL RELATED PARTY LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2).** | | | | $2,116,674 | $- | $1,939,253 | | $34,399 |

Medicaid PopID & Provider Number 408-100034556

## 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 D. Begin date 1/1/2020 Begin Bal. | E. 6Mo.date 4/30/2020 6 Mo. Bal. | F. End date 7/31/2020 End Bal. | G. Interest Rate | H. Interest Expense |
|---|---|---|---|---|---|---|---|---|
| 8. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 9. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 10. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 11. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 12. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 13. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |
| 14. Name<br>Related party? ☐ Yes ☐ No<br>Purpose | | | | | | | | |

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

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 34: Depreciation Expenses

**SECTION A - CAPITALIZED HISTORICAL COST**

| | Begin Date 1/1/2020<br>B. Beginning Balance | C. Additions During Report Period | D. Disposals During Report Period | End Date 7/31/2020<br>E. Ending Balance |
|---|---|---|---|---|
| 1. Land | | | ( ) | $- |
| 2. Land Improvements | | | ( ) | - |
| 3. Buildings | | | ( ) | - |
| 4. Leasehold Improvements | 53,153 | | ( ) | 53,153 |
| 5. Fixed equipment | | | ( ) | - |
| 6. Moveable equipment | 230,342 | | ( ) | 230,342 |
| 7. Transportation vehicles | 15,989 | | ( ) | 15,989 |
| 8. | | | ( ) | - |
| 9. | | | ( ) | - |
| 10. TOTAL CAPITALIZED COST . . | $299,484 | $- | ( $- ) | $299,484 |

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

| | A. Depreciation Method, Lives Used | Begin Date 1/1/2020<br>B. Beginning Balance | C. Depreciation Exp. During Report Period | D. Removal of Accum. Deprec. On Disposals. | End Date 7/31/2020<br>E. Ending Balance |
|---|---|---|---|---|---|
| 11. Land Improvements | | | | ( ) | $- |
| 12. Buildings | | | | ( ) | - |
| 13. Leasehold Improvements | | 36,090 | 5,457 | ( ) | 41,547 |
| 14. Fixed equipment | | | | ( ) | - |
| 15. Moveable equipment | | 195,983 | 8,686 | ( ) | 204,669 |
| 16. Transportation vehicles | | 15,990 | | ( ) | 15,990 |
| 17. | | | | ( ) | - |
| 18. | | | | ( ) | - |
| 19. TOTAL ACCUMULATED DEPRECIATION | | $248,063 | | ( $- ) | $262,206 |
| **20. TOTAL DEPRECIATION EXPENSE** | | | **$14,143** | | |

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

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 34RP: Related Party Depreciation Expenses

**SECTION A - CAPITALIZED HISTORICAL COST**

| | Begin Date 1/1/2020<br>B. Beginning Balance | C. Additions During Report Period | D. Disposals During Report Period | End Date 7/31/2020<br>E. Ending Balance |
|---|---|---|---|---|
| 1. Land | $355,362 | | ( ) | $355,362 |
| 2. Land Improvements | | | ( ) | - |
| 3. Buildings | 1,754,586 | | ( ) | 1,754,586 |
| 4. Leasehold Improvements | 35,529 | | ( ) | 35,529 |
| 5. Fixed equipment | | | ( ) | - |
| 6. Moveable equipment | 366,274 | | ( ) | 366,274 |
| 7. Transportation vehicles | | | ( ) | - |
| 8. | | | ( ) | - |
| 9. | | | ( ) | - |
| 10. TOTAL CAPITALIZED COST . . | $2,511,751 | $- | ( $- ) | $2,511,751 |

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

| | A. Depreciation Method, Lives Used | Begin Date 1/1/2020<br>B. Beginning Balance | C. Depreciation Exp. During Report Period | D. Removal of Accum. Deprec. On Disposals. | End Date 7/31/2020<br>E. Ending Balance |
|---|---|---|---|---|---|
| 11. Land Improvements | | | | ( ) | $- |
| 12. Buildings | | 377,462 | 34,117 | ( ) | 411,579 |
| 13. Leasehold Improvements | | 16,580 | 1,382 | ( ) | 17,962 |
| 14. Fixed equipment | | | | ( ) | - |
| 15. Moveable equipment | | 361,087 | 726 | ( ) | 361,813 |
| 16. Transportation vehicles | | | | ( ) | - |
| 17. | | | | ( ) | - |
| 18. | | | | ( ) | - |
| 19. TOTAL ACCUMULATED DEPRECIATION | | $755,129 | | ( $- ) | $791,354 |
| **20. TOTAL DEPRECIATION EXPENSE** | | | **$36,225** | | |

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

**Medicaid PopID & Provider Number** 408-100034556

# 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. | ERSTAD ENTERPRISES LTD | [x] Yes [ ] No | [ ] Yes [x] No | | Jan-13 | BUILDING | $52,500 |
| 2. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |
| 3. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |

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

| | A. Name of Lessor | B. Related Party? | C. Lease Purchase Agreement? | D. Lessor Acquisition Cost (If known) | E. Lease Inception Date (MM/YY) | F. Describe Property | G. Lease Exp. |
|---|---|---|---|---|---|---|---|
| 4. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |
| 5. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |
| 6. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |
| 7. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |
| 8. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |
| 9. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |
| 10. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |
| 11. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |
| 12. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |
| 13. | | [ ] Yes [ ] No | [ ] Yes [ ] No | | | | |

## SECTION C - TOTAL

**14. TOTAL LEASE EXPENSE ON OPERATING LEASES AND NON-CAPITALIZED LEASES** **$52,500**

# 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** . . . . . **$-**

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 36B: Capitalized Leases

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

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

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

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

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

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

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

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

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

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

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 37: Property Taxes

**SECTION A - FOR ALL PROVIDERS**

| | | Expense |
|---|---|---|
| 1. | 2020 Real Estate Tax Bill | $22,746 |
| 2. | 2020 Personal Property Tax Bill | 2,246 |

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

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

3b. Are there any real estate or personal property tax still outstanding from prior years, eg. 2018 or 2019? [ ] Yes, explain below [x] 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 . . . . . $24,992**

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 37RP: Related Party Property Taxes

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

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

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

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

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

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

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

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

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

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

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

## SCHEDULE 38 - NO LONGER USED

## SCHEDULE 39 - NO LONGER USED

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 40: Allocated Property Expenses

| | | | | Areas for Non-NH Serv. Or Other Major Revenue-Generating Activities | | |
|---|---|---|---|---|---|---|
| | | | | C. | D. | E. |
| **SECTION A - DIRECT PROPERTY EXP.** | **A. Total From Sched.** | **B. NH Service Area** | | | | |
| 1. Property insurance (s31) | $6,491 | | | | | |
| 2. Mortgage insurance (s31) | - | | | | | |
| 3. Amortization debt premium discount (s32) | 116 | | | | | |
| 4. Plant asset interest expense (s33) | - | | | | | |
| 5. Depreciation land improvements (s34) | - | | | | | |
| 6. Depreciation buildings (s34) | - | | | | | |
| 7. Depreciation leasehold improve. (s34) | 5,457 | | | | | |
| 8. Depreciation fixed equipment (s34) | - | | | | | |
| 9. Depreciation moveable equip. (s34) | 8,686 | | | | | |
| 10. Depreciation transportation veh. (s34) | - | | | | | |
| 11. Depreciation other (s34) | - | | | | | |
| 12. Expense on operating leases (s35) | 52,500 | | | | | |
| 13. Expense on capitalized leases (s36) | - | | | | | |
| 14. Property taxes or fees (s37) | 24,992 | | | | | |
| 15. TOTAL EXPENSE | $98,242 | $- | | | | |
| 16. Less total directly assigned property exp. | $- | | | | | |
| **17. NET UNASSIGNED/INDIRECT PROP. . . . .** | **$98,242** | | | | | |
| **SECTION B - NON-SALARY EXPENSES** | **A. Total From Sched.** | **B. NH Area** | | | | |
| 18. Square feet of service's building area | 18,680 | 18,680 | | | | |
| 19. Ratio to total square feet to 4 decimals | 1.0000 | 1.0000 | | | | |
| 20. Indirect property expense allocation | $98,242 (from 17A) | 98,242 20A x 19B | | - 20A x 19C | - 20A x 19D | - 20A x 19E |
| **SECTION C - TOTAL** | **A. Total From Sched.** | **B. NH Area** | | | | |
| **21. TOTAL PROP. EXP. FOR EACH AREA** | **$98,242** 17A + 20 A | **$98,242** 15B + 20B | | **$-** 15C + 20C | **$-** 15D + 20D | **$-** 15E + 20E |

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 41: Paid Time-Off Expenses

## SECTION A - POLICIES AND PRACTICES

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

2. Capitalization of plant assets - briefly describe the facility's policy or practice for the capitalization of plant assets purchases.
EQUIPMENT HAS AN ESTIMATED USEFUL LIFE OF 2 YEARS AND AN ACQUISITION COST OF $1,000.

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

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

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

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

## SECTION A - RELATED PARTY LEASES

| | A. Description of Expense Item | Location and Amount of Expense Included in This Cost Report | | | | |
|---|---|---|---|---|---|---|
| | | B. Cost Ctr. | C. Schedule | D. Column | E. Line | F. Net Expense |
| 1. | Total related party lease expense | BUILDING | 35 | G | 1 | $(52,500) |
| 2. | Insurance expense | | | | | |
| 3. | Amortization deferred expense | AMORT | 32RP | G | 5 | 1,154 |
| 4. | Interest expense | INTEREST | 33RP | H | 15 | 34,399 |
| 5. | Depreciation expense | DEPREC | 34RP | C | 20 | 36,225 |
| 6. | Property tax expense | | | | | |
| 7. | | | | | | |
| 8. | | | | | | |
| 9. | SUBTOTAL FOR RELATED PARTY LEASES | | | | | $19,278 |

## 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)** . . . . . | | | | | $19,278 |

## 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.

ERSTAD ENTERPRISES LTD

**Medicaid PopID & Provider Number** 408-100034556

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

| | A. Description of Expense Item | Amount | Location of Expense in Cost Report: Cost Ctr. | Schedule | Column | Line |
|---|---|---|---|---|---|---|
| 1. | Promotional expenses | $924 | ADMIN | 26ATT | 1 | 3 |
| 2. | Gifts and flowers | | | | | |
| 3. | Personal expenses of owners | | | | | |
| 4. | Entertainment for non-residents | | | | | |
| 5. | Telephone, television, internet and cable service in resident rooms | | | | | |
| 6. | Contributions and donations | | | | | |
| 7. | Fines and penalties | | | | | |
| 8. | Interest expense on non-care working capital loans | | | | | |
| 9. | Interest expense on non-care plant asset loans | | | | | |
| 10. | Non-care related membership fees | | | | | |
| 11. | Training programs for non-employes | | | | | |
| 12. | Special legal and professional fees | | | | | |
| 13. | Owner or key person life insurance | | | | | |
| 14. | Taxes | | | | | |
| 15. | Fund raising expenses | | | | | |
| 16. | Excess property | | | | | |
| 17. | Out of State Travel (Destination) | | | | | |
| 18. | Gift, flower, or coffee shops and snack counters | | | | | |
| 19. | Reorganization, stockholder, or stock purchase expenses | | | | | |
| 20. | Goodwill and Abondoned Planning Expenses | | | | | |
| 21 | Other - describe: BED ASSESSMENT | 57,925 | ADMIN | 26 | 1 | 9 |
| 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.

Medicaid PopID & Provider Number 408-100034556

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

| | 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

| | Name of Individual or Entity | Percentage of Ownership |
|---|---|---|
| 1. | GRAVES ENTERPRISES, INC. | 100% |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

## SCHEDULE 50: Interest in Other Providers

| | Name and City of Medicaid Provider | Type of Medical Services Provided | Nature and Extent of Interest in Provider |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

## SCHEDULE 51 - NO LONGER USED

**Medicaid PopID & Provider Number** 408-100034556

# SCHEDULE 52: Miscellaneous Medicaid Non-Rate Revenues

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

# 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 | 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